TennCare Operational Protocol

Incorporating Amendments to the Demonstration Approved in 2006

Bureau of TennCare
Nashville, Tennessee

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Table of Contents

List of Tables

Table

List of Abbreviations Used in This Document

ACCENT	Automated Client Certification and Eligibility Network for Tennessee
ADA-CDT	American Dental Association—Current Dental Terminology
BHO	Behavioral Health Organization
BPN	Best Practice Network
CBER	Center for Business and Economic Research
CDC	Centers for Disease Control and Prevention
CAHPS	Consumer Assessment of Health Plans Study
CMS	Centers for Medicare and Medicaid Services
COBRA	Consolidated Omnibus Budget Reconciliation Act
CPE	Certified Public Expenditure
CPT	Current Procedural Terminology
CRA	Contractor Risk Agreement
CSA	Community Service Area or Community Service Agency
DBM	Dental Benefits Manager
DCS	[Tennessee] Department of Children Services
DHS	[Tennessee] Department of Human Services
DMHDD	*See TDMHDD*
DMRS	[Tennessee] Division of Mental Retardation Services
DOH	[Tennessee] Department of Health
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQRO	External Quality Review Organization
FFP	Federal Financial Participation
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FTP	File Transfer Protocol
FY	Fiscal Year
HCBS	Home and Community Based Services
HCFA	Health Care Financing Administration
HCPCS	HCFA Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HEDIS	Health Plan Employer Data and Information Set
ICD-9	International Classification of Diseases, 9th Revision
ICF/MR	Intermediate Care Facility for the Mentally Retarded
IHS	Indian Health Service
IRS	Internal Revenue Service
IS	Information Systems
MCC	Managed Care Contractor
MCO	Managed Care Organization
ME	Medically Eligible
MEQC	Medicaid Eligibility Quality Control
MNIS	Medically Needy Income Standard
MR	Mental Retardation
NCPDP	National Council for Prescription Drug Programs
NCQA	National Committee for Quality Assurance
OOP	Out-of-Pocket
PBM	Pharmacy Benefits Manager
PCP	Primary Care Provider

PLHSO	Prepaid Limited Health Service Organization
PMPM	Per Member Per Month
POS	Point of Service
PSA	Public Service Announcement
RFI	Request for Information
SED	Seriously Emotionally Disturbed
SFY	State Fiscal Year (July 1 through June 30)
SPA	State Plan Amendment
SPMI	Severely and/or Persistently Mentally Ill
SSA	Social Security Administration
SSD	Standard Spend Down
SSI	Supplemental Security Income
TANF	Temporary Aid to Needy Families
TCMIS	TennCare Management Information System
TDCI	Tennessee Department of Commerce and Insurance
TDMHDD	Tennessee Department of Mental Health and Developmental Disabilities
TPA	Third Party Administrator
TPG	Target Population Group
TPL	Third Party Liability
TSU	TennCare Solutions Unit
YDC	Youth Development Center

List of "User Friendly" Definitions

Note: For legal purposes, the definitions in the state rules and the state's contracts are to be used. The following list is intended to provide "user friendly" definitions for general reference only.

Applicant. A person who has applied for TennCare but whose application has not been approved or denied.

Authorization date. The date that an application from a person in the demonstration population has been approved for TennCare.

Case. A household that includes some members who are TennCare eligible.

Closed enrollment. A period of time during which the only persons who can enroll in TennCare as new members are those found eligible in an active Medicaid category.

Consumer Assessment of Health Plans Study (CAHPS). A set of standardized surveys that measure patient satisfaction with experience of care. CAHPS is sponsored by the Agency for Health Care Quality.

Demonstration eligible. Persons who are not eligible under Tennessee's State Plan but who are otherwise eligible for the TennCare demonstration project. Demonstration eligibles are enrolled in TennCare Standard.

Demonstration project. A project approved by the Centers for Medicare and Medicaid Services, which allows certain Medicaid statutes and regulations to be "waived" for the purpose of "demonstrating" or "testing" a principle or set of principles about health care. TennCare is a demonstration project designed to show that a managed care approach can be used to extend coverage to people who would not otherwise be eligible for Medicaid, without costing the state more money than the state would have spent on a Medicaid program only and without compromising service quality.

Disenrollment. This term is used in two ways by TennCare. 42 CFR 438.56 uses the term "disenrollment" to refer to the process by which individuals change MCOs. TennCare has historically used the term "disenrollment" to refer to the process by which a person who has lost eligibility for TennCare is removed from the program. Attachment E to the Special Terms and Conditions, which was originally approved by CMS on March 14, 2005, uses the term "disenrollment" in this manner. The proper interpretation of the term thus depends upon the context in which it is used.

Dual eligible. A person who is eligible for both Medicare and TennCare, meaning he is eligible in a TennCare category that permits access to insurance AND he has Medicare.

A "true dual" is a person who is entitled to all the benefits of Medicare and all the benefits of TennCare. He gets most of his services from Medicare, and he also gets the services TennCare covers that Medicare does not cover. Two examples of services that TennCare covers but Medicare does not are non-emergency transportation and mental health case management.

Eligible. A person who has been determined eligible for TennCare.

Enrollee. A person who has been determined eligible for TennCare and who has been enrolled in the program.

Family. Parents and related children who live together in the same household. "Related" individuals include parents' spouses who live in the home, as well as siblings, half-siblings, and step-siblings. Caretakers (such as grandparents) who are not parents but who are present in the home are not included in the definition of "family" unless they request to be included. Children living at home are removed from the "family" once they turn 19 (for TennCare Standard) or 21 (for TennCare Medicaid) or they marry, whichever comes first.

Health Plan Employer Data and Information Set (HEDIS). The most widely used set of performance measures in the managed care industry, designed to allow reliable comparison of the performance of managed health care plans. HEDIS is developed and maintained by the National Committee for Quality Assurance.

Immediate eligibility. A process by which children entering state custody (other than those going into Youth Development Centers) are assigned to TennCare Select so that they can start receiving TennCare-reimbursed health care services immediately. If the result of the eligibility determination process is that the child is not eligible for TennCare, DCS will refund to TennCare Select any payments made on the child's behalf.

There is also an immediate eligibility process for persons applying to enroll in certain Home and Community Based Services Programs as set forth in State Rule 1200-13-1-.02(5). This allows an individual to begin receiving home and community based long term care services sooner than he otherwise would, in order to avoid institutionalization. To qualify for immediate eligibility, a person must be applying for enrollment into an applicable HCBS waiver program, be determined by TennCare to meet eligibility criteria for admission to a Level I Nursing Facility or ICF/MR, as applicable (i.e., have an approved Pre-Admission Evaluation), have submitted an application for financial eligibility determination to DHS, and be expected, based on preliminary review of financial information, to qualify for TennCare Medicaid. If the result of the eligibility determination process by DHS is that the person is not eligible for TennCare Medicaid, any long term care services provided will be reimbursed with state funds, and FFP will not be claimed.

Income. Monies received such as salaries, wages, pensions, certain rental income, interest income, dividends, royalties, etc., which produce a gain or a benefit to the recipient.

Institutionalized. TennCare enrollees who are receiving TennCare-reimbursed long term care in nursing facilities, intermediate care facilities for the mentally retarded, or under a home and community based services waiver program.

Marketing. TennCare uses the term "marketing" to refer to all contacts made by managed care entities with enrollees, including letters, enrollee satisfaction surveys, newsletters, etc.

Medicaid. The program for medical assistance provided under Title XIX of the Social Security Act for certain persons with low incomes and special circumstances. Medicaid programs are administered jointly by the state and the federal government.

Medicaid eligible. People who are eligible under Tennessee's State Plan (otherwise known as "TennCare Medicaid").

Medicaid Rollover. Persons who are under age 19 who lack access to insurance and whose Medicaid eligibility is ending. These persons must have incomes below 200% of poverty OR be determined "Medically Eligible" at any income level in order to "roll over" into TennCare Standard. Medicaid Rollovers must complete their applications within specified time periods.

Medically Eligible. An uninsured person under age 19 who is not Medicaid eligible and who qualifies for TennCare Standard based on certain medical conditions.

Medicare. The program for medical assistance provided under Title XVIII of the Social Security Act for elderly and certain disabled individuals. The Medicare program is administered solely by the federal government.

National Committee for Quality Assurance (NCQA). A nonprofit organization committed to assessing, reporting on, and improving the quality of care provided by organized delivery systems. Useful information on NCQA may be accessed at the NCQA website: www.ncqa.org.

Open enrollment. A period of time announced by the state during which enrollment in a specified category is open and applications for that category are accepted.

Presumptive eligibility. An established period of time (45 days) during which certain individuals—pregnant women; women identified by the Centers for Disease Control and Prevention (CDC) as being uninsured and needing treatment for breast or cervical cancer—are eligible for Medicaid. During this period of time the presumptively eligible person must complete an application and qualify for Medicaid in order to stay on the program.

Resources. Assets such as savings accounts, personal property, etc., which are available to an individual. Resources are not counted for persons in the demonstration population. However, enrollees in the TennCare Standard Spend Down (SSD) population will have resources counted in accordance with the criteria that apply to Medically Needy pregnant women and children under the State Plan.

Retroactive eligibility. Eligibility which begins as of a date in the past. TennCare eligibility is effective on the date of application, if the applicant is subsequently approved, or the date of the qualifying event (such as the date that Spend Down is met), whichever is later. TennCare eligibles do not get automatic periods of retroactive eligibility in Tennessee as Medicaid eligibles do in other states. This regulation was "waived" for the TennCare demonstration project, since it is difficult to manage care for people whose enrollment date is prior to their enrollment into a managed care plan.

Reverification. The annual process that occurs for all demonstration eligibles during which they must provide documentation that they continue to meet the eligibility requirements for TennCare in order to stay on the program.

Spend Down. A term associated with the Medicaid Medically Needy program, which is an optional eligibility category that states may choose to cover in their Medicaid programs. See 42 CFR 436 Subpart D. To "spend down" means that one has a sufficient amount of unreimbursed medical bills to reduce his monthly income to the state's Medically Needy Income Standard (MNIS). TennCare covers pregnant women and children to age 21 in its Medicaid Medically Needy program. Non-pregnant adults who were enrolled in the program as of April 29, 2005, or who had an application in process on that date that was subsequently approved, are remaining in the Medicaid Medically Needy program until the Standard Spend Down program (described below) is open. No new enrollment is occurring for non-pregnant adults who would otherwise qualify for the Medicaid Medically Needy program.

Standard Spend Down (SSD). An eligibility category in TennCare Standard. Standard Spend Down enrollees are defined as non-pregnant adults aged 21 and older who are aged, blind, disabled, or caretaker relatives of Medicaid-eligible children and who have met Spend Down criteria patterned after the criteria used in the Medicaid Medically Needy program. This category will be open for enrollment after the extension to the current TennCare waiver that expires on June 30, 2007, has been approved by CMS. The SSD program will have an enrollment target of 100,000 people.

Transitional Medicaid. The availability of continuing Medicaid coverage for a period after an individual has ceased receiving benefits under the Families First (TANF) program.

Uninsurable. Under the previous TennCare demonstration, a person who did not have insurance, who did not have access to insurance other than Medicare, and who had been turned down for insurance because of a health condition. This category is replaced by "Medically Eligible" in the current demonstration.

Uninsured. A person who is not insured and who lacks access to group health insurance.

Waiver. See definition of "Demonstration Project."

Understanding TennCare Terms

TennCare is the name for the state's Section 1115(a) managed care demonstration.

TennCare Select is the name of the managed care plan that is contracted by the state to handle special populations of enrollees with complex medical needs and to be available in any area where there is inadequate MCO capacity. TennCare Select is also intended to serve as a back-up if one of the other managed care plans leaves the project unexpectedly.

TennCare Partners is the portion of the TennCare project that deals with behavioral health services.

TennCare Medicaid is the name for the package of benefits available for people who are eligible for Medicaid.

TennCare Standard is the name for the package of benefits available for people who are uninsured and Medically Eligible, or enrolled in the Standard Spend Down program once that program has opened. (See definition of Standard Spend Down on page 9.).

TennCare Assist is the name for the employer-subsidized insurance project. This program has not been implemented.

Part One: Overview

1.1 Organizational and Structural Configuration of the Demonstration

1.1.1 Background

On January 1, 1994, the state of Tennessee implemented the TennCare demonstration (No. 11-W-00002/4) as a five year demonstration project approved by the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) under Section 1115 of the Social Security Act. A three-year extension of the demonstration was granted through December 2001. Early in 2002, a one-year extension was granted to continue the demonstration through January 31, 2003.

A set of project modifications for a new TennCare demonstration was requested from CMS early in 2002. The new demonstration, which replaced the previous TennCare demonstration, was approved in May 2002 for an effective date of July 1, 2002. The number of the new demonstration is No. 11-W-00151/4.

On September 24, 2004, the Bureau of TennCare requested a number of modifications to the TennCare demonstration project. Following submission of this request, subsequent meetings with the public, and enrollee advocates in particular, the Bureau submitted a supplement to the September proposals on February 18, 2005. These changes were requested in order to stabilize and protect the TennCare project. In separate letters dated March 24, 2005, June 8, 2005, and March 31, 2006. CMS approved several of the modifications requested. This Operational Protocol provides details on the implementation of the amended demonstration project.

The current TennCare demonstration expires on June 30, 2007. An extension request has been submitted to CMS but not yet approved as of the date of this Operational Protocol.

1.1.2 Organization and Structure

The TennCare demonstration project is administered by the Bureau of TennCare, which is a division of the Tennessee Department of Finance and Administration. The Department of Finance and Administration oversees all state spending, and the Commissioner of the department serves as Chief Financial Officer to the Governor.

The Bureau of TennCare is headed by a Deputy Commissioner. Divisions within the Bureau include:

- Office of the Medical Director
- Operations
- Member Services
- Network Operations
- Financial Operations
- Information Systems

- Policy
- Office of General Counsel
- Long-Term Care[1]
- Public Affairs
- Internal Audit
- Non-discrimination Compliance and Health Care Disparities

An abbreviated organization chart for the Bureau of TennCare can be found in Attachment A.

Other state departments administer portions of the TennCare project, under the direction of the Single State Agency (the Department of Finance and Administration). These state departments, together with the specific TennCare functions that they carry out, are shown in the table below.

Table 1
State Agencies Involved in the TennCare Demonstration Project

Agency	Functions
Office of the Comptroller	• Performance of TennCare audits • Performance of MCO and BHO audits • Quarterly audits of the implementation of the *Grier* Consent Decree • Establishment of Nursing Facility and ICF/MR rates
Department of Children's Services	• Determination of Medicaid eligibility for children coming into custody • Provision of targeted case management for TennCare-eligible children in state custody and at risk of state custody • Provision of residential treatment services for TennCare-eligible children in state custody • EPSDT outreach
Department of Commerce and Insurance	• Licensure of HMOs/MCOs, PLHSOs/BHOs, and TPA/DBMs • Financial oversight of HMOs/MCOs, PLHSOs/BHOs, and TPA/DBMs • Administration of the TennCare Claims Processing Panel and Independent Review Process for review of denied claims submitted by providers • Establishment and enforcement of uniform claim form instruction standards • Administration of annual MCO/BHO network adequacy study • Operational oversight of HMOs, PLHSOs/BHOs and

[1] The Long-Term Care Division oversees the nursing facility programs and the Home and Community Based Services waivers. While these programs are outside of the TennCare waiver, persons enrolled in these programs are also enrolled in TennCare.

Agency	Functions
	TPA/DBMs, including: monitoring financial solvency, oversight, and review and approval of holding company systems activities and transactions; oversight of timeliness and accuracy of claims processing and payment of provider claims; subcontract and provider agreement review and approval; review of evidence of coverage, including member handbooks and provider manuals; and state law and CRA compliance of HMO, PLHSO/BHO, TPA operational subcontractors
Department of Education	• EPSDT outreach
Department of Health	• EPSDT outreach • EPSDT screenings • Provision of dental screenings and services to children • Presumptive eligibility determinations for pregnant women • Presumptive eligibility determinations for uninsured women needing treatment for breast and/or cervical cancer • Enrollee education and advocacy
Department of Human Services	• TennCare eligibility determinations • Provision of education and assistance regarding the TennCare eligibility process • Family assistance information line • Appeals of eligibility-related issues • EPSDT outreach
Department of Mental Health and Developmental Disabilities	• Oversight of the TennCare Partners Program • Development of policy for the TennCare Partners Program • Evaluation of the TennCare Partners Program • Review of BHO provider networks • EPSDT outreach
Division of Mental Retardation Services	• EPSDT outreach
Governor's Office of Children's Care Coordination	• Coordinates EPSDT activities among state departments

A number of contractors are involved in delivering TennCare services. These contractors include all of the managed care entities (MCOs, BHOs, DBM, and PBM) plus others shown in the table below.

Table 2
Major TennCare Administrative Contractors

Contractor	Major Functions
EDS	• Claims processing for long-term care • Claims processing for Medicare crossover payments • Maintenance of eligibility subsystem • Maintenance of encounter data • Ad hoc and regular reports
Schaller-Anderson of Tennessee	• Review of medical appeals • Assistance with medical policy
Aon	• Actuarial studies
Blue Cross/Blue Shield of Tennessee	• TennCare Select contract
QSource (EQRO)	• Quality reviews of MCOs and BHOs • Special studies

Provisions of the approved amendments to the TennCare demonstration are incorporated in the following chapters.

1.2 Evaluation Design

The purpose of the TennCare project is to demonstrate that a Medicaid managed care program can be organized in such a way as to save the state enough dollars to be able to expand coverage to people who are not Medicaid-eligible, while at the same time ensuring access to quality care for all enrollees.

There are many different evaluation mechanisms in place for various components of the TennCare project. The domains of the overall evaluation design, however, include the following:

- Spending on TennCare versus spending on Medicaid
- Access to care for enrollees
- Quality of care
- Enrollee satisfaction
- Health status indicators
- Stability and viability of health plans

TennCare has developed measures for each of the above elements. These measures, together with the frequency of use, are shown in Table 3 on the next page.

Table 3
Overall TennCare Evaluation Measures

Domain	Measures	Frequency of Measurement
Spending on TennCare versus spending on Medicaid	Budget neutrality tests.	6 months after the end of an individual demonstration year (per Special Terms and Conditions)
Access to care for enrollees	Findings from the CAHPS survey[2] on the categories of "Getting needed care" and "Getting needed care quickly."	Annually
	Progress on selected HEDIS measures (e.g., Child and Adolescent immunization status and Breast and Cervical Cancer screening).	Annually
	Progress on EPSDT screening ratios, as reported on the CMS 416.	Annually
	Responses to annual beneficiary satisfaction survey, "Time between attempt to make appointment and first availability of appointment," "Waits for appointments."	Annually, in September of each year (per Special Term and Conditions)
Quality of care	Findings from the CAHPS survey on the category "How well doctors communicate."	Annually
	Progress on selected HEDIS measures, such as "Appropriate medications for people with asthma," "Cholesterol management after acute cardiovascular events," "Comprehensive diabetes care," Controlling high blood pressure," "Advising smokers to quit," and "Demonstration of clinical and service quality management."	Annually
	Progress on NCQA standards in areas such as "Disease management," "Use of clinical practice guidelines," and "Demonstration of clinical and service quality improvement."	Annually
	Medical record reviews of EPSDT screenings to determine the completeness of screenings.	Annually
	Responses to annual beneficiary satisfaction survey, "Quality of medical care received by	Annually, in September of each

[2] Tennessee required all existing MCOs to obtain NCQA-accreditation by January 1, 2007. (Subsequent MCOs will be required to obtain accreditation within an established period of time after joining the program.) In order to obtain NCQA accreditation, the MCO must contract with an independent survey vendor certified by NCQA to administer an annual standardized Consumer Assessment of Health Plan Survey (CAHPS).

Domain	Measures	Frequency of Measurement
	heads of household," and "Quality of medical care received by children of heads of household."	year (per Special Term and Conditions)
	Analysis of Network Adequacy Report– to ensure that each MCC is delivering benefits within the required time frames, and that each MCC has an adequate provider network to ensure effective and efficient delivery of healthcare services to TennCare enrollees.	Annually
	Annual Quality Survey which provides an overall, review analysis and recommendations of the MCCs overall integration of the health care delivery system and assessment of quality of care.	Annually
Enrollee satisfaction	Responses to annual beneficiary satisfaction survey.	Annually, in September of each year (per Special Term and Conditions)
	Findings from the CAHPS instrument on the following four overall ratings of consumer experience: "Rating of all health care," "Rating of health plan," "Rating of personal doctor," and "Rating of specialist seen most often." Composite results are based on consumer experience in the following three categories: "Claims processing," "Courteous and helpful office staff," and "Customer service."	Annually
Health status indicators	EPSDT compliance.	Quarterly
	Childhood immunization status.	Annually, by DOH
	Inpatient admissions per 1,000.	Quarterly
	Non-emergency ER visits per 1,000.	Quarterly
Stability and viability of health care plans	MCO/BHO network adequacy study (performed by TDCI).	Annually
	Reviews of compliance by TDCI with prompt pay requirements.	Monthly
	Reviews of compliance by TDCI with MCO/BHO net worth requirements.	Quarterly

Reports on the findings associated with these measurements will be summarized in the quarterly and annual reports that TennCare files with CMS, pursuant to Special Terms and Conditions.

Part Two: Eligibility and Enrollment

2.1 Eligibility Criteria

2.1.1 Overview

This chapter provides a description of the populations covered by TennCare. These include Medicaid eligibles, as well as non-Medicaid eligible children under the age of 19 who are the current remaining members of the "demonstration population." These groups are summarized in Table 4.

CMS has provided approval for adding a new demonstration population known as "TennCare Standard Spend Down (SSD)." Those eligible for this category are non-pregnant adults (aged, disabled, blind, caretaker relatives of Medicaid-eligible children) who have met Spend Down criteria patterned after those used in the Medicaid Medically Needy program. An enrollment target of 100,000 persons has been set for this category. Enrollment into this category will begin after CMS approves the extension of the TennCare waiver, which expires on June 30, 2007.

Table 4
Eligibility Groups in the 2007 TennCare Demonstration

TennCare Project	Eligibility Group	Description
TennCare Medicaid	Group A	Tennessee residents who have been determined eligible for Medicaid.
	Group B	Tennessee women who are uninsured or whose insurance does not cover treatment for breast or cervical cancer, who are under age 65, and who have been determined through a Centers for Disease Control site to need treatment for breast or cervical cancer.
TennCare Standard	Group C	Tennessee residents who are children under age 19, who are uninsured, who do not have access to group health insurance, and who have incomes below 200% of poverty*.
	Group D	Tennessee residents at any income level* who are children under age 19, who are uninsured, who do not have access to group health insurance, and who are determined to be "Medically Eligible" by the state.
	Group E	Tennessee residents who were enrolled as uninsured children in TennCare as of December 31, 2001, even if they had access to insurance, because their family incomes were below 200% of poverty and who continue to meet the criteria of being under the age of 19 and with family incomes below 200% of poverty.

TennCare Project	Eligibility Group	Description
	Group F	Standard Spend Down enrollees. These are non-pregnant adults (aged, disabled, blind, caretaker relatives of Medicaid-eligible children) who have met Spend Down criteria patterned after those criteria used in the Medicaid Medically Needy program. (Category not yet open.)

*NOTE: Income levels are subject to revision downward, depending upon the funding level determined by the General Assembly and the availability of funds within the federal budget neutrality cap.

2.1.2 TennCare Medicaid

All persons who would be eligible for Medicaid under the eligibility rules specified in Tennessee's State Plan for Medical Assistance (provided in accordance with Title XIX of the Social Security Act) are eligible for TennCare. Included in this group are Categorically and Medically Needy individuals, as well as Medicare beneficiaries who are also eligible for Medicaid. (The only Medically Needy categories currently open to new enrollment are pregnant women and children.) Qualified Medicare Beneficiaries (QMBs) and Specified Low Income Medicare Beneficiaries (SLMBs) are covered for Medicare cost-sharing, but do not participate in TennCare Medicaid unless they are also eligible in a Medicaid category.

Applicants for Supplemental Security Income (SSI) apply for that program through the Social Security Administration (SSA). Once determined eligible by SSA, they are automatically enrolled in Medicaid, with an effective date assigned to them by SSA.

Other applicants for TennCare coverage are assessed for Medicaid eligibility, using the eligibility rules specified in the Tennessee State Plan for Medical Assistance, the State of Tennessee's Title XIX program. These eligibility determinations are conducted by the Tennessee Department of Human Services at local DHS offices throughout the state. As of the close of business on April 29, 2005, however, enrollment for the non-pregnant adult Medicaid Medically Needy categories was closed to new applicants.

2.1.3 TennCare Standard

The non-Medicaid demonstration population for TennCare is the population enrolled in TennCare Standard.

The following groups are included in TennCare Standard:

Group 1: Uninsured low-income[3] children. These are children who are either already enrolled in TennCare or who have lost Medicaid eligibility and have been able to transition to this group as a "Medicaid Rollover." They must lack access to insurance, be under age 19, and have family incomes that do not exceed 200% poverty.

Group 2: Uninsured Medically Eligible children. These are children who are either already enrolled in TennCare or who have lost Medicaid eligibility and have been able to transition to

[3] Low income is defined by the Tennessee State Legislature as a percentage of the Federal Poverty Level and is annually established for purposes of TennCare Standard eligibility. The income level will not exceed 200% of FPL.

this group as a “Medicaid Rollover.” They must lack access to insurance, be under age 19, and meet the criteria for “Medically Eligible.” There is no income limit.

Group 3: Grandfathered uninsured children. There are uninsured children who were eligible for TennCare as of December 31, 2001, even if they had access to insurance but whose family incomes were below 200% poverty. In order to stay in this eligibility group, children must remain continuously enrolled, and they must continue to meet income standards, to lack access to insurance, and to be under the age of 19. Group 3 is a "grandfathered" group from the previous TennCare project. All of the persons in this "grandfathered" group will continue to be enrolled in TennCare as long as they are continuously enrolled in their “grandfathered” category and they continue to meet all program requirements. If there is a break in coverage for any reason, such as non-payment of premiums, persons disenrolled from a "grandfathered" group will not be able to re-enroll in that group. They will be treated like new applicants if they apply again for TennCare. Persons in the "grandfathered" groups who become Medicaid-eligible will not be able to return to their "grandfathered" group when their eligibility for Medicaid ends. They will be allowed to apply for TennCare like other Medicaid Rollovers when their Medicaid is over.

Group 4: Standard Spend Down enrollees. (Category not yet open.) These are non-pregnant adults (aged, disabled, blind, caretaker relatives of Medicaid-eligible children) who have met Spend Down criteria patterned after those criteria used in the Medicaid Medically Needy program. (See definition on page 9.)

As of the close of business on April 29, 2005, TennCare Standard enrollment was closed to new applicants. Only children under the age of 19 already enrolled in TennCare Standard and those whose Medicaid eligibility is ending and who meet the TennCare Standard eligibility criteria either as Uninsured or as Medically Eligible are eligible for TennCare Standard.

2.1.3.1 Technical eligibility criteria

All members of the demonstration population must meet the following technical eligibility criteria: they must be residents of the State of Tennessee, they must be United States citizens or legal resident aliens, they must have met Social Security enumeration requirements, and they must not be incarcerated.

2.1.3.2 Access to insurance

“Access to insurance” is a very important concept in TennCare. Persons in TennCare Standard other than those in the Standard Spend Down program must lack access to health insurance. The types of policies that count as “insurance” and the types of policies that do not count as “insurance” for purposes of determining uninsured status are presented in Table 5.

2.1.3.3 Income levels

For enrollees other than those in the Standard Spend Down program, all persons in the demonstration population are screened for income. Resources are not counted. Enrollees in the Standard Spend Down program have the same Spend Down levels and resource requirements as pregnant women and children served in the Medicaid Medically Needy program.

The family income level is calculated by DHS according to the current federal poverty level (FPL) standards, using definitions of “family” and “income” that are similar to those used for Medicaid applicants. Income is used to determine premiums to be paid to the state. For demonstration project eligibles, the income limit is set by the demonstration project and may be modified by the General Assembly each year. Those eligibles having family incomes at or

greater than 100% of poverty will be required to pay premiums and copays, both of which are discussed in section 3.2.

Table 5
Definitions of "Insurance" under TennCare

Types of Policies that Count as "Insurance"	Types of Policies that Do Not Count as "Insurance"
A hospital and medical expense-incurred policy, Medicare, TRICARE, COBRA, Medicaid, State health risk pool (Access Tennessee), Nonprofit health care service plan contract, Health maintenance organization subscriber contract, An employee welfare benefit plan to the extent that the plan provides medical care to an employee or his dependents (as defined under the terms of the plan) directly through insurance, any form of self-insurance, or a reimbursement mechanism, Coverage available to an individual through membership in a professional organization or a school, Coverage under a policy covering one person or all the members of a family under a single policy where the contract exists solely between the individual and the insurance company, or Any of the above types of policies which may have been termed "limited benefits" policies in the past because: The policy contains a type of benefit (such as mental health benefits) which has been completely exhausted, The policy contains a type of benefit (such as pharmacy) for which an annual limitation has been reached. The policy has a specific exclusion or rider of non-coverage based on a specific prior existing condition or an existing condition or treatment of such a condition. People with any of the types of policies listed above will be considered "insured" by TennCare even if one or more of the following circumstances exists: The policy contains fewer benefits than TennCare, The policy costs more than TennCare, The policy is one the individual could have bought during a specified period of time (such as COBRA) but chose not to.	Short-term coverage, Accident coverage, Fixed indemnity insurance, Long-term care insurance, Disability income contracts, Limited benefits policies, meaning a policy of health coverage for a specific disease (such as cancer), or an accident occurring while engaged in a specified activity (such as school-based sports), or a policy which provides for a cash benefit payable directly to the insured in the event of an accident or hospitalization (for example, hospital indemnity), Credit insurance, School-sponsored sports-related injury coverage, Coverage issued as a supplement to liability insurance, Automobile medical payment insurance, Insurance under which benefits are payable with or without regard to fault and which are statutorily required to be contained in any liability insurance policy or equivalent self-insurance, A medical care program of the Indian Health Services (IHS) or a tribal organization, Benefits received through the Veteran's Administration, or Health care provided through a government clinic or program such as, but not limited to, vaccinations, flu shots, mammograms, and care or services received through a disease- or condition-specific program such as, but not limited to, the Ryan White Act.

2.2 TennCare Application Process

2.2.1 Overview: Applying for TennCare Medicaid

Persons meeting Medicaid eligibility criteria can enroll at any time. All applicants for TennCare, except SSI recipients and children in state custody, must complete a written application and be interviewed by a worker with the Department of Human Services (DHS). SSI applicants apply through the Social Security Administration (SSA) and are automatically enrolled in TennCare Medicaid upon approval of SSI benefits. Children coming into state custody are enrolled through the Department of Children's Services. They have access to an arrangement called "immediate eligibility," which is discussed in section 2.2.6.

Pregnant women can apply for presumptive eligibility status at local health departments and other sites designated by the Department of Health through the Title V agreement. If they meet the requirements, they become immediately eligible for 45 days of TennCare. They must follow up with applications through DHS in order to continue benefits past the 45-day period.

Women who are under age 65, who are uninsured or have insurance which does not cover treatment for breast or cervical cancer, and who have been determined to be in need of treatment for breast or cervical cancer may be screened for presumptive eligibility for Medicaid by a Centers for Disease Control and Prevention (CDC) site such as the health department. Presumptive eligibility lasts for a period of 45 days. During the presumptive eligibility period, the enrollee must go to the DHS office to complete her enrollment in Medicaid. The DHS worker first evaluates the woman to determine if she is eligible for any other Medicaid category. If she is not eligible in another Medicaid category, the worker evaluates her for the optional Medicaid category to cover her during the time she needs treatment for cervical or breast cancer. A re-determination of eligibility will occur at least every 12 months at the DHS office and will be based on the need for continuing treatment for breast or cervical cancer, as determined by the woman's treating physician.

Applicants other than SSI applicants usually complete a portion of the application prior to the actual face-to-face interview. During the interview, the DHS worker and the applicant(s) jointly complete the remainder of the application. Persons who are unable to complete the applicant sections of the full application are assisted by DHS workers during the interview process (see Procedures for Accommodations at the end of this section). Applicant information is keyed on-line during the interview (in most cases) or from a workbook manually completed by a DHS worker at a later time (only occasionally).

The state's automated eligibility system (ACCENT) determines Medicaid eligibility by category based on the information entered. Medicaid eligibility is determined within the time periods provided for in federal regulations, and the applicant is notified by DHS of the result of this process. Appeals of denials of Medicaid eligibility are handled by DHS.

2.2.2 Overview: Applying for TennCare Standard

2.2.2.1 Uninsured child eligibility

Children under age 19 whose Medicaid eligibility is ending are screened for TennCare Standard. If the applicant lacks access to insurance and has income below the specified poverty level, he may be eligible for the TennCare Standard Uninsured category. If the applicant meets all the technical eligibility criteria for TennCare Standard and is ineligible solely because of excess income, the applicant is offered an opportunity to apply in the Medically Eligible (ME) category.

Uninsured children under age 19 whose Medicaid eligibility is ending but who qualify for TennCare Standard and who file timely applications will be allowed to move immediately into TennCare Standard as Medicaid Rollovers, assuming they meet the income and/or Medical Eligibility criteria in place at the time. They will not experience a break in coverage.

2.2.2.2 Medical Eligibility

There are two options that an applicant may use to apply for Medical Eligibility. Both of the processes begin with an eligibility determination at the local Department of Human Services. Any child under age 19 whose Medicaid eligibility is ending, who is uninsured, and who meets all of the technical requirements for TennCare Standard but has income over 200% of poverty will be given an opportunity to apply as Medically Eligible by completing a special packet. The options for Medical Eligibility are shown in Table 6.

Table 6
Options for Medical Eligibility

Options	General Description for the Period Beginning April 30, 2005
Qualifying Medical Condition	The applicant must either have his physician attest that he has a medical condition on the TennCare list, *or* the applicant must submit, along with the completed application, appropriate medical records to support the attestation of a medical condition *not* included on the TennCare list, and a release for additional medical records, if necessary.
SED	The applicant must have a recent assessment as SED (Serious Emotional Disturbance). He must provide attestation by a licensed mental health professional of the diagnosis that supports the basis for the TPG assessment, as well as the medical records to support that diagnosis. TennCare will review available encounter data and, if the encounter data shows that the person has been assessed as SED within the past year, he will not be required to submit additional medical information.

For Option 1 (“Qualifying Medical Condition”), TennCare has prepared a listing of diseases/conditions that will be used to determine Medical Eligibility (see Attachment B). The diseases/conditions selected represent serious and/or chronic conditions requiring continued monitoring and/or treatment. Due to the serious nature of these diseases/conditions, most Tennessee insurance companies will deny coverage to individuals with a medical history that includes one or more of these diseases/conditions.

“Medical records” are defined in TCA 63-2-101(c)(2) as “medical histories, records, reports and summaries, diagnoses, prognoses, records of treatment and medication ordered and given, x-

ray and radiology interpretations, physical therapy charts and notes, and lab reports." Applicants for Medically Eligible status are not required to submit all the medical records they may have. Rather, they are required to submit a copy of a current medical record or portion of a medical record that documents the existence of the medical condition they have said that they have. A lab test may be sufficient in some circumstances. However, the lab test cannot be "anonymous"—it must be clearly identified as belonging to the person applying for Medically Eligible status.

Each of the methods above requires the applicant to include with the completed application all supporting documentation. Only complete applications accompanied by the required supporting documentation will be processed.

Eligibility for those children who qualify as Uninsured or as Medically Eligible will begin on the initial application date and will not reflect a break in coverage from the child's previous Medicaid coverage.

Medically Eligible TennCare Standard enrollees must renew their TennCare eligibility on the same schedule as other TennCare enrollees. Renewing TennCare eligibility means updating information on income, family size, access to insurance, etc. However, the medical criteria for Medical Eligibility will not be verified annually for those who remain on the program without a break in coverage.

2.2.2.3 Standard Spend Down eligibility

CMS has provided approval for adding a new demonstration population known as "TennCare Standard Spend Down (SSD)." Those eligible for this category are non-pregnant adults (aged, disabled, blind, caretaker relatives of Medicaid-eligible children) who have met Spend Down criteria patterned after those used in the Medicaid Medically Needy program. An enrollment target of 100,000 persons has been set for this category. Enrollment into this category will begin after CMS approves the extension of the TennCare waiver, which expires on June 30, 2007.

2.2.3 Effective Date of Eligibility

2.2.3.1 SSI eligibles: The date determined by the Social Security Administration in approving the individuals for SSI coverage.

2.2.3.2 All other Medicaid eligibles: The date of the application, or the date of the qualifying event (such as the date that a spend-down obligation is met), whichever is later.

The date of application for Medicaid is:

- The date a signed application form is received in the county DHS office. The "begin date" for Medicaid is the application date or the date all eligibility requirements are met, whichever is later (example: a child applies for Medically Needy coverage but does not meet Spend Down until two weeks after the application date; the effective date of his Medicaid eligibility in this case would be the date he met Spend Down) or
- The date a faxed application is received at DHS. Eligibility begins either the date of the fax or the date all eligibility requirements are met, whichever is later.

There are two presumptive eligibility categories in TennCare Medicaid. One is for pregnant women, and the other is for women under age 65 who are uninsured or whose insurance does not cover treatment for breast or cervical cancer and who have been found by CDC to need

treatment for these conditions. The effective date of eligibility in either category is the date an application is approved at the Department of Health or at any alternative sites chosen by the Department of Health.

Persons enrolling in TennCare in an open Medically Needy category or in the SSD program, once it is open, get an automatic year of TennCare coverage.

2.2.3.3 Demonstration eligibles under age 19: For persons under age 19 whose Medicaid eligibility is ending and who meet the eligibility requirements for TennCare Standard either as Uninsured or as Medically Eligible, the date of eligibility will be the next day following the close of the Medicaid segment, and if the enrollee has premiums, the premium will begin on the date of eligibility.

2.2.3.4 TennCare Standard Spend Down: The date of eligibility for those enrolled in the TennCare Standard Spend Down program is detailed in Attachment H to the Special Terms and Conditions as approved on November 14, 2006.

2.2.4 Re-Establishment of Eligibility

Eligibility in all TennCare categories will have a “begin date” and an “end date”. A person may remain on TennCare past his end date only if he reapplies and is determined to be eligible for a new period of eligibility. All TennCare enrollees must re-establish their ongoing eligibility for TennCare on at least an annual basis. Ex parte reviews conducted by DHS, Request for Information notices, and/or face-to-face meetings between the DHS worker and the enrollee are the means by which this is accomplished. Enrollees will be required to provide updated information on their employment, income, assets, family status and other pertinent issues.

The determination that an individual meets the medical criteria for Medical Eligibility for TennCare Standard will not be reverified every year, since most of the conditions are chronic conditions that are lifelong. However, people who are Medically Eligible will still have to renew their TennCare coverage each year and provide updated information on residency, changes in income, and access to group health insurance.

Changes in income, family status or living circumstances (including address changes) that occur in the interim periods between “begin” and “end” dates of coverage must be reported by the enrollee to his DHS worker within 30 days, in accordance with TCA 71-5-110. Failure to report such changes in a timely manner may result in termination from the program.

2.2.5 Rollover Eligibility for Individuals under Age 19

If an enrollee under the age of 19 loses eligibility for TennCare Medicaid, he may apply for TennCare Standard and, if eligible, be enrolled in TennCare Standard without a break in coverage, unless the loss of eligibility is due to incarceration or non-resident status. People who enroll in this way are called “Medicaid Rollovers.” (Persons who lose eligibility because they are incarcerated or who move permanently out-of-state are not eligible to continue on TennCare as "Medicaid Rollovers.") Enrollees who are children under the age of 19 moving from Medicaid to TennCare Standard will receive the same benefits as were included in their TennCare Medicaid benefit package. Thereafter, these enrollees must re-establish eligibility for TennCare Standard at announced intervals, which will occur at least within a 12 month period. Enrollees losing eligibility for TennCare Standard are provided with Certificates of Creditable Coverage, as required under the Health Insurance Portability and Accountability Act (HIPAA). Persons who

are denied TennCare Standard eligibility will receive timely notice of their denial and appeal rights.

Individuals who voluntarily terminate their TennCare coverage will also be provided with timely Certificates of Creditable Coverage.

2.2.6 Presumptive Eligibility and Immediate Eligibility

Presumptive eligibility for pregnant women is conducted consistent with the standards and criteria followed by Tennessee Medicaid and in accordance with its approved Medicaid State Plan. Presumptively eligible pregnant women have 45 days to complete the full eligibility determination process. During the presumptive period, the woman is considered to be a "temporary" Medicaid enrollee; if she does not go to DHS and become eligible in a Medicaid category, she will not be permitted to stay on TennCare when her presumptive period ends.

There is also presumptive eligibility for certain uninsured women identified by a CDC (Centers for Disease Control and Prevention) site as requiring the need for treatment for breast or cervical cancer. Women who are under age 65, who are uninsured or whose insurance does not cover treatment for breast or cervical cancer, and who have been screened at a CDC site and determined to be in need of treatment for breast or cervical cancer may be determined to be presumptively eligible for Medicaid at the CDC site. They then go to their county DHS office for determination of eligibility beyond the 45-day presumptive period. Coverage in this category is limited to the period during which a woman requires treatment for the breast or cervical cancer. Coverage is provided to these women who would not otherwise be eligible for Medicaid.

There is no presumptive eligibility for children, except that children entering state custody are deemed “immediately eligible” for TennCare while their TennCare applications are being processed. Should the result of the eligibility determination process be that the children are not eligible for TennCare, DCS will reimburse TennCare Select for any dollars spent on these children's behalf.

There is also an immediate eligibility process for persons applying to enroll in certain Home and Community Based Services Programs as set forth in State Rule 1200-13-1-.02(5). This allows an individual to begin receiving home and community based long term care services sooner than he otherwise would, in order to avoid institutionalization. To qualify for immediate eligibility, a person must be applying for enrollment into an applicable HCBS waiver program, be determined by TennCare to meet eligibility criteria for admission to a Level I Nursing Facility or ICF/MR, as applicable (i.e., have an approved Pre-Admission Evaluation), have submitted an application for financial eligibility determination to DHS, and be expected, based on preliminary review of financial information, to qualify for TennCare Medicaid. If the result of the eligibility determination process by DHS is that the person is not eligible for TennCare Medicaid, any long term care services provided will be reimbursed with state funds, and FFP will not be claimed.

2.2.7 Newborns

TennCare coverage is automatically granted to any infant born to a Medicaid-eligible mother, on the date of birth. It is also granted, on the date of birth, to any infant born to a TennCare Standard-eligible mother if the TennCare Standard category in which the mother is enrolled is open for enrollment. Parents or family representatives must take steps to get the infant enumerated for Social Security purposes, however, so that he will not fail the TennCare technical eligibility requirement that every enrollee has a valid Social Security Number.

For newborns, a hospital worker may provide to the mother, family member, or a family representative an SS5 Form to complete for the purpose of assigning a Social Security number to the newborn. The hospital worker or a DHS worker may assist in completing the SS5 Form, which is an application for a Social Security number/card. DHS is allowed to bypass the requirement that the newborn be enumerated if there is verification that an SS5 Form has been completed.

The MCO in which the mother is enrolled at the time of delivery will be responsible for the coverage and payment of all TennCare-covered services provided to the newborn, beginning at birth. Infants on TennCare Standard are automatically assessed for potential Medicaid eligibility at the mother's next annual visit at DHS for re-establishment of eligibility. New mothers may voluntarily present to their DHS worker for an assessment of Medicaid eligibility for their child at any time and, in fact, are encouraged to do so.

2.2.8 Procedures for Accommodating Persons with Other Disabilities and Limited English Proficiency

In the spring of 2001, the Bureau of TennCare, led by the Division of Policy and then the Division of Member Services, began meeting with various consumer advocacy groups and other interested individuals to open a dialogue about TennCare and enrollee issues, especially those involving reaching those enrollees with disabilities or limited English proficiency. These are issues that are important to both TennCare and the advocates. This group has been meeting regularly since then to discuss advocacy/outreach issues. Such meetings have been beneficial to both sides by providing a better understanding of the issues involved and improved communications with the TennCare enrollee population.

2.2.8.1 Individuals with limited English proficiency (LEP)

Both the TennCare Bureau and the Department of Human Services have made a number of provisions to assist individuals with LEP as they navigate the disenrollment and/or application process for TennCare eligibility.

Both agencies have applications available in English and Spanish. In addition, TennCare mails notices in English and Spanish, and DHS mails them in English or Spanish, depending upon what the individual has indicated that Spanish s his primary language. An insert in each mailing provides a toll-free phone number that individuals may call for assistance in translation. These inserts have this information in Arabic, Somali, Kurdish-Badinani, Kurdish-Sorani, Bosnian, and Vietnamese. In addition, all notices contain the number of the Family Assistance Service Center (formerly, the TennCare Information Line); through that number, a connection can be made with the AT&T Language Line for translation services, if necessary.

The TennCare Bureau also maintains a contract with Health Assist Tennessee, an advocacy group, which operates the TennCare Advocacy Program (formerly the Consumer Advocacy Line). The TennCare Advocacy Program provides outreach and advocacy assistance to persons with limited English proficiency, as well as translation services to TennCare enrollees and applicants. This program can also direct enrollees and applicants to local community translation resources.

The Department of Human Services also provides translation services, through bi-lingual staff, a contract with the AT&T Language Line, and through contracted and volunteer community translators.

Both the TennCare Bureau and DHS maintain access to text telephones for the hearing impaired, and DHS also has sign language interpreters and readers for the visually impaired on contract. Finally, in order to assist individuals who do not read with the disenrollment process, the TennCare Bureau developed a special green flag for the envelopes that it is using to send RFI notices to TennCare enrollees and, in PSAs and other written and oral communications, directs enrollees to look for the green letters on the envelope and take the material to someone who can assist them in understanding the material.

2.2.8.2 People with physical and other disabilities

The following strategies are in place to assist clients with a wide range of disabling conditions that might make the disenrollment or application process more difficult.

DHS has been performing eligibility determinations for Medicaid, Food Stamps, and its Families First program for many years. The Department has a lengthy list of accommodations that it has made and will continue to make available to the TennCare population. These accommodations include:

- Letting the enrollee/applicant designate a third party to represent him during the eligibility determination process;
- Conducting the interview with an individual over the phone;
- Conducting the interview at an alternative site that is easier for the enrollee/applicant to access;
- Conducting the interview outside of normal working hours;
- In extreme cases, conducting the interview in the enrollee's home.

2.2.9 MEQC

The Department of Human Services presently conducts an alternative Medicaid Eligibility Quality Control (MEQC) Project for the Medicaid eligible population. The Bureau of TennCare conducts a separate alternative MEQC Project for the uninsured, uninsurable, and Medicaid "rollover" populations; this project was approved by CMS in August 2000. The Bureau has a contract with Dr. William F. Fox with the University of Tennessee's Center for Business and Economic Research (CBER) to do the separate alternative MEQC project.

CBER uses a random monthly sample selection methodology, with two six-month samples drawn per year. Two separate groups are sampled: active cases (those eligibles currently in the system) and negative cases (eligibles who are terminated and persons whose applications have been denied.) CBER gathers the data and conducts the surveys on both groups and forwards their results to TennCare for review by an "an external source". This means that TennCare's external source makes a decision as to whether a case is in error or not. Results from the review are resubmitted to CBER, which then produces a written report analyzing the findings and actions taken. A final report is submitted to the Bureau of TennCare and reviewed by an. external source, which is required to be staff independent of those responsible for eligibility policy operations (State Medicaid Manual, Part 7, Section 7005.1). Beginning in State Fiscal Year 2008, DHS will conduct the MEQC program for the uninsured, Medically Eligible, and Medicaid "rollover" populations.

2.3 Enrollment Process

2.3.1 Overview

Managed Care Organizations (MCOs) are Health Maintenance Organizations (HMOs) under contract with the Bureau of TennCare to serve TennCare Medicaid and Standard enrollees. MCOs provide a comprehensive range of physical health care services to TennCare enrollees through a network of health care providers. Information about eligibility and enrollment, the MCOs, and covered services may be obtained by calling the DHS Family Assistance Service Center's toll-free number (1-866-311-4287), or by accessing the Bureau of TennCare's website (www.tennessee.gov/tenncare).

The Bureau of TennCare contracts with 9 Managed Care Organizations (MCOs) to provide services to enrollees. MCOs provide all covered services (other than behavioral health and long-term care) to TennCare enrollees. BHOs provide all covered behavioral health services, except for pharmacy, to TennCare enrollees. Beginning on April 1, 2007, two (2) new MCOs began operations in the Middle Tennessee Grand Region. Unlike the current MCOs, these new MCOs have assumed the responsibility for both the medical services and the behavioral health services needed by their enrollees. A list of the current MCOs and BHOs is contained in Attachment C.

TennCare Standard enrollees receive a benefit package that includes a comprehensive array of covered services. The package is designed to be similar to a standard HMO benefit package. TennCare Standard members are enrolled in MCOs for their physical health care and BHOs for their mental health and substance abuse treatment needs.

TennCare Select is a state-organized health plan that is administered by Volunteer State Health Plan. TennCare Select is available for certain groups of special needs children, such as SSI children and children who are in institutional placements or alternatives to institutional placements. Parent or legal guardians of these children can "opt out" of TennCare Select during change periods if they choose. TennCare-eligible children in state custody are enrolled in TennCare Select. In addition, TennCare Select serves as the health plan for TennCare enrollees who are temporarily out-of-state. Neither children in state custody nor enrollees who are temporarily out-of-state can "opt out" of TennCare Select.

TennCare Select further functions as the "safety net" health plan should an MCO exit the TennCare project unexpectedly. In such a situation, the exiting plan's members will be assigned to TennCare Select. Such assignments are temporary, and enrollees are transitioned to another MCO as soon as one becomes available in their geographic area. The Bureau gives notice to these enrollees of their temporary assignment to TennCare Select and instructs them in the procedures for accessing covered health care services. TennCare Select is not open for voluntary selection on the part of enrollees.

Behavioral Health Organizations (BHOs) are prepaid health care plans that provide behavioral health services only. The program for delivering covered behavioral and substance abuse services is known as the "Partners" program.

2.3.2. Procedures for Enrollment into MCOs

At the time the application for TennCare is completed, the applicant selects an MCO from among those available in his area. All family members in the same case must enroll in the same

MCO, except for children eligible to enroll in TennCare Select. Individuals who are returning to TennCare after a lapse in eligibility will be re-assigned to their former MCO if the lapse in eligibility has been for less than 63 days. This assignment is an initial assignment only; members are given 45 calendar days (inclusive of mail time) from the date of the letter informing of their re-enrollment in TennCare to change MCOs if they wish. If the applicant is subsequently approved for TennCare Medicaid or TennCare Standard, enrollment in the MCO will be effective on the same day that coverage in the program becomes effective.

Applicants who fail to select an MCO at their DHS interview are assigned to one that is available in the area in which they live. MCOs issue identification cards to enrollees, and such cards are used to access services from MCO network providers. Once enrolled, TennCare eligibles have 45 calendar days (inclusive of mail time) from the date of the letter of their notification of MCO assignment to change MCOs if they are dissatisfied with their MCO for any reason. After the 45 day change period, enrollees can only change MCOs based on proof of hardship criteria (see Attachment D) or once during the annual reverification visit. TennCare also permits changes to put all family members in the same MCO, unless one of the family members is in TennCare Select. The TennCare Solutions Unit within the Bureau reviews and issues decisions on MCO change requests related to medical or service access issues.

Each MCO is responsible for providing a Bureau-approved Member Handbook to each enrollee immediately upon being notified of the enrollee's eligibility.

2.3.3 Procedures for Enrollment into BHOs

TennCare Medicaid and TennCare Standard enrollees are automatically enrolled in the BHO which is paired with the MCO to which they belong. The BHO also issues identification cards and Member Handbooks to its enrollees.

2.3.4 Procedures for Enrollment into TennCare Select

The Department of Children's Services determines Medicaid eligibility for children in custody, and the Social Security Administration determines eligibility for children who qualify for SSI benefits. Eligibility files are transferred to TennCare Select from these agencies, and identification cards and Member Handbooks are issued. Other groups are enrolled in TennCare Select when there is a need, such as when there is inadequate MCO capacity in an area.

2.3.5 Procedures for Changing MCOs/BHOs

Enrollees are given their choice of health plans when possible. Once enrolled, the new enrollee may change MCOs (if an alternate plan is available) within the first 45 calendar days (inclusive of mail time) from the date of the letter of enrollment and MCO assignment. Thereafter, the enrollee must remain in the assigned MCO until he is given an opportunity to change MCOs during his next recertification interview. Only one change is permitted per year unless the enrollee moves out of the area served by his plan or a change is approved through the resolution of an enrollee appeal.

When an enrollee requests to change his MCO, TSU reviews the request to change MCOs against the six "hardship criteria" (see Attachment D). If the six criteria are not met, a denial letter is issued, including the right to appeal the denial of the enrollee's request.

Enrollees, after requesting and obtaining the approval of the TennCare Bureau, may be permitted to change enrollment to a different health plan. In the event an enrollee changes plans, the enrollee's medical care will be the responsibility of the original health plan until the date that the new MCO assignment is effective.

An enrollee must change MCOs if he moves outside the MCO's Community Service Area (CSA) and that MCO does not operate in the enrollee's new area of residence. Until the enrollee selects or is assigned to a new MCO, his medical care is the responsibility of the original MCO.

Enrollees will be given the opportunity to select a new health plan if their MCO withdraws from participation in TennCare and is no longer available. If a selection is not made timely, the enrollee will be assigned to an available MCO operating in the CSA. The enrollee will have 45 calendar days (inclusive of mail time) from the date of the letter of MCO assignment to change MCOs if he wishes.

2.3.6 Procedures for Annual Notification of Members

In keeping with the notice requirements outlined in the federal managed care regulations at 42 CFR 438.10(f), the state will provide a standard insert to go in its mailings to enrollees regarding enrollment matters. Enrollees will receive this information at least once a year.

2.3.7 Special Populations

This section describes how special populations are served within TennCare. The section is organized in two main subsections. The first includes a brief discussion of how special needs are met within mainstream managed care organizations, the behavioral health organizations, and the state's plan, TennCare Select. The second subsection addresses specific special needs populations within TennCare, including special needs children and children in state custody; Medicaid and Medicare dual eligibles; and aliens and refugees.

2.3.7.1 Provisions for special populations within managed care models

The TennCare project includes a number of individuals with special health care needs. Most of these individuals are successfully served through the mainstream managed care organizations (MCOs). Tennessee has developed and implemented rigorous plan participation standards to ensure that mainstream MCOs have networks and quality management programs necessary to adequately serve populations with special needs. These plan participation standards are described in the MCO contract.

Some special needs populations, including children in state custody, are enrolled in the state's self-insured health plan called TennCare Select. This plan was developed to address the needs of special populations such as SSI children and children in the custody of the state.

TennCare enrollees receive necessary behavioral health services through contracted Behavioral Health Organizations (BHOs). Tennessee has developed standards for Behavioral Health Organizations similar to those for physical health MCOs. These standards are described in the BHO Contractor Risk Agreement.

2.3.7.2 Special needs children

EPSDT services are available for special needs children who are Medicaid-eligible, just as they are for other Medicaid-eligible children.

All TennCare-eligible children in state custody (other than those living in Youth Development Centers (YDCs) are enrolled in TennCare Select for physical health services and care coordination. Children already enrolled in TennCare and who are residing in a YDC are eligible to receive TennCare-covered inpatient hospital services, but not other TennCare covered services, except for services delivered pursuant to the *Grier* Revised Consent Decree.

Children who leave state custody and who continue to be TennCare eligible remain in TennCare Select for a period of time to assure a smooth transition of care. Behavioral health services are provided by a BHO that has partnered with TennCare Select. In addition, children in or at risk of coming into state custody and who continue to be TennCare-eligible receive specialized services managed by the Department of Children's Services. For children at risk of custody, these services include targeted case management. For children in custody, these services include targeted case management and the treatment components of residential care. Each child is assigned a TennCare Select Primary Care Provider (PCP) responsible for coordinating health and behavioral health care services among all care providers. These PCPs are part of a Best Practice Network (BPN), which is discussed in more detail in Part 4.

2.3.7.3 Persons with Medicare

Medicaid/Medicare enrollees ("dual eligibles") receive services through the regular TennCare program. Pharmacy services for dual eligibles are provided by Medicare Part D. For children who have both Medicare and TennCare, TennCare provides prescription benefits for TennCare-covered drugs which are not covered by Medicare.

From July 1, 2002, through December 31, 2005, dual eligibles were served in a Section 1915(b) waiver approved by CMS. Effective January 1, 2006, the state exercised authority granted by CMS to transfer dual eligibles from its Section 1915 (b) waiver to the Section 1115 demonstration. The purpose of this transfer was to enroll these eligibles in a managed care delivery system.

2.3.7.4 Aliens and refugees

Legal aliens and refugees continue to be eligible for TennCare if they meet Medicaid or TennCare Standard eligibility criteria, and they are enrolled in MCOs and BHOs in the same manner as all other TennCare enrollees. Refugees are eligible for eight months after they arrive in the United States.

Emergency services for undocumented aliens continue to be provided as federally mandated. Undocumented aliens are assigned to TennCare Select for the length of time of their emergency, and may not be reassigned to a different health plan.

The state has taken a number of steps to ensure that TennCare is accessible for individuals who may not be English-proficient. All written TennCare educational materials and all enrollee notices have been translated into Spanish. All TennCare educational materials and enrollee notices are mailed with information providing a special telephone number through the TennCare Advocacy Program (formerly the TennCare Consumer Advocacy Line) for enrollees who speak Bosnian, Arabic, Somali, Vietnamese, and two dialects of Kurdish (Sorani and Badinani). MCOs and BHOs are required to have their member handbooks and vital documents available in Spanish. Contractors are required to provide appropriate interpretation services to assist enrollees with understanding the handbooks or vital documents. In addition, TennCare works with local organizations that serve the refugee populations, including those providing telephone

translation services. TennCare contractors are responsible for assuring the provision of on-site language assistance for enrollees when necessary.

In addition, as part of the administrative appeals and hearing process, translators and interpreters are provided for all TennCare enrollees who need language assistance, at no cost to the enrollee. Attachments to the letter which is sent to enrollees outlining their appeal rights include a telephone number where they can get assistance in completing the appeal forms, as well as information on how to access free or low cost legal representation, and information on locating translators and/or interpreters.

2.3.8 Disenrollment of Medically Needy Medicare/Medicaid Dual Eligibles

In late 2005, the Bureau began implementing authority granted under the March 24, 2005, and June 8, 2005, TennCare demonstration amendments to begin disenrolling adults who were Medicare/Medicaid dual eligibles and who were eligible in a Medically Needy category other than pregnant women and children under age 21. The Bureau moved ahead on disenrolling these persons because people with Medicare have access to insurance and, at the time, there were no plans to enroll persons who had access to insurance in the SSD program. Individuals were required to meet **all** of the following criteria to be selected for disenrollment:

- They are eligible for Medicare Part A or B and therefore eligible for Medicare Part D on or after January 1, 2006; AND
- They have reached the end of the 12 months of eligibility they received when they were determined to be Medically Needy; AND
- They have not been determined to be eligible in any active Medicaid category.

For those dual eligibles who met the above criteria and who reached the end of their current year of eligibility, the Bureau implemented the Request for Information and disenrollment processes, pursuant to Attachment E of TennCare's Special Terms and Conditions.

At the request of CMS, TennCare stopped initiation of disenrollment for this population on May 17, 2006. The SSD program design was later revised to allow persons with other insurance, including Medicare, to enroll.

The process for moving currently enrolled non-pregnant Medically Needy adults, including those who are dually eligible for Medicare and Medicaid, to the SSD program will begin within one month of the date that CMS approves the state's request for an extension of the waiver that expires on June 30, 2007. Persons in this population who are not found to be eligible for the SSD program or for an active Medicaid category will be disenrolled from TennCare.

2.4 Enrollee Marketing and Outreach Strategy

2.4.1 Marketing Activities and Restrictions

Marketing guidelines are included in Managed Care Organization contracts. Key points are summarized below.

Managed care organizations (MCOs) must submit a detailed marketing plan, all marketing materials and a description of marketing activities to TennCare for review and approval prior to

implementation or use. All written marketing materials must be worded at a reading level that does not exceed sixth grade and must be printed with a minimum font size of 12 points. Materials must be made available in English and Spanish and in the language of any other Limited English Proficiency group identified by TennCare that constitutes five percent of the TennCare population or 1,000 enrollees, whichever is less.

Written materials must be made available in alternative formats or appropriate interpretation services must be provided for persons with special needs.

MCOs are permitted to distribute approved material through mass media and through general activities that benefit the entire community, such as health fairs. Telephone calls, mailings or home visits to current enrollees are permitted only for the purpose of educating current enrollees about services offered by the MCO.

The following activities are prohibited:

- Use of materials or activities that mislead, confuse, defraud, or are unfair;
- Use of overly aggressive solicitation;
- Gifts and offers of material or financial gain as incentives to enroll;
- Compensation arrangements with marketing personnel that tie compensation to the number of persons enrolled;
- Direct solicitation of prospective enrollees;
- Use of independent marketing agents.

2.4.2 Monitoring of Enrollee Marketing Activities

The primary focus of monitoring activities is on preventing potential marketing abuses by requiring the prior review and approval of detailed marketing plans and all marketing materials. In the event that marketing abuses are suspected or reported, additional monitoring activities may include member surveys, random audits, or undercover observation of marketing activities. Each of these activities is described below.

2.4.2.1 Review and approval of enrollee marketing plans and activities

As set forth in the Contractor Risk Agreement, MCOs must submit detailed descriptions of all proposed marketing activities as well as copies of all marketing materials to be used. These include: all policies and marketing manuals; advertisement copy; brochures; posters; fact sheets; video tapes; story boards for production of videos; audio tapes; newsletters; telemarketing scripts; and any other forms of advertisement as well as other forms of public contact such as participation in health fairs.

The marketing plans and materials are reviewed to ensure that proposed activities are permitted under state and federal marketing guidelines. TennCare will approve, deny or return the plan with comments within 15 days. Once approved marketing materials have been produced, copies of the final product must be submitted to TennCare. TDMHDD will review BHO marketing materials.

2.4.2.2 Member surveys

If marketing abuses are identified or suspected, targeted member surveys will be conducted. The surveys may be designed to focus on a specific MCO or BHO, or may be conducted across all participating MCOs. The surveys may be conducted by telephone, mail or a combination, depending on the nature of the marketing problems being investigated.

Examples of questions that could be included in marketing surveys are:

- Has any MCO called you or sent you materials in the mail? If yes, did you request a call or materials in advance?
- Did you speak with any MCO representatives prior to enrolling in TennCare? If yes, where did you speak with the representative?
- Was the information you received helpful?
- Was the MCO representative polite?
- Did any MCO offer you a gift if you enrolled?

Results will be summarized and reviewed by the TennCare staff, who will determine the appropriate response, including further audits or investigations, written warnings to the MCO, or initiation of corrective action.

2.4.2.3 Random audits

If TennCare believes that violations of the marketing guidelines have occurred, further audits or surveys may be conducted. The type of audit or survey will depend on the nature of the suspected problem. For example, unannounced visits to health fairs or other MCO marketing sites can be implemented to observe interaction between marketing representatives and potential enrollees, obtain samples of marketing materials being distributed, and conduct brief interviews with potential enrollees to elicit feedback on the marketing activities and information received.

2.4.2.4 Corrective action

TennCare has a wide range of remedies available in the event of marketing abuses. The following specific remedies are included in the contract:

- Revocation of previously approved marketing activities;
- Imposition of financial sanctions including liquidated damages;
- Suspension of enrollment;
- Disenrollment of MCO enrollees; or
- Limitations of the MCO's service area.

MCOs are required to develop and implement corrective actions to remedy the marketing problem(s). Any or all of the above sanctions may be imposed until such time as the state is satisfied that the problem has been resolved.

Part Three: Benefits and Cost-Sharing

3.1 Benefits

The physical health and mental health benefits provided to TennCare enrollees are listed in Attachment F to this Operational Protocol. All TennCare-covered services must be medically necessary; however medical necessity alone does not qualify a service as being TennCare-covered.

A brief description of each benefit is included in Attachment F. More detailed descriptions of some of the benefits are contained in state rules. In addition, state rules provide a list of the specific services that are excluded from coverage. See Tennessee Rules 1200-13-13-.10 and 1200-13-14-.10.

Several benefit changes have been implemented over the past two years, with some services being eliminated. Limits have been placed on two services for adults aged 21 and older. These services are (a) outpatient pharmacy services for all adults except those being served in Nursing Facilities or HCBS waiver programs, and (b) inpatient and outpatient substance abuse treatment services for all adults. Even with these changes, however, TennCare continues to offer a robust benefit package with a broad array of services for enrollees.

3.2 Cost Sharing

3.2.1 Overview

TennCare Standard enrollees with incomes at or above 100% of poverty must pay a share of the cost of their health care services. TennCare Standard cost sharing occurs in two ways: monthly premiums and copays for specific services. Pharmacy copays apply to TennCare Standard enrollees, as well as to Medicaid adults who do not belong to one of the groups mentioned in 42 CFR 447.53 for whom copays are excluded. This section describes premiums and co-payments under the TennCare project.

3.2.2 Premiums

Premiums are set on a sliding scale basis depending on family size and income. They are calculated by the DHS ACCENT system using information provided by applicants and verified during the interview at DHS. Each year, premiums may increase by an amount not to exceed the percentage of the aggregate per capita budget increase necessary to sustain the managed care portion of the TennCare project. Premiums are adjusted each year at the same time the poverty level is updated. Individuals can always appeal their premium amounts if they believe these are incorrect.

Current TennCare Premiums are shown in Table 7.

Table 7
TennCare Premium Chart

Percentage of Poverty	0% - 99%	100% - 149%	150% - 199%	200% - 249%	250% - 299%
Individual Monthly Premium	$0	$20.00	$35.00	$100.00	$150.00
Family Monthly Premium	$0	$40.00	$70.00	$250.00	$375.00
Percentage of Poverty	300% - 349%	350% - 399%	400% - 499%	500% - 599%	600% - Over
Individual Monthly Premium	$200.00	$250.00	$350.00	$450.00	$550.00
Family Monthly Premium	$500.00	$625.00	$875.00	$1,125.00	$1,375.00

3.2.2.1 Premium calculation

Premiums are calculated by Department of Human Services (DHS) workers at the applicant's interview.

If approved, a letter will be generated and sent from TennCare stating that the person has met TennCare Standard eligibility requirements effective on a certain date and premiums will be billed accordingly.

For those persons already enrolled in TennCare Standard whose eligibility is being reviewed during a renewal visit, the current billing/dunning process will apply. The DHS worker will not have a role in the premium process since the enrollee is already a TennCare member and is aware of the premium responsibilities. If the premium amount is changing due to change in income or family size, a notice sent from TennCare will inform the enrollee of the new premium amount.

3.2.2.2 Collection and posting of premiums

TennCare issues a premium statement on a monthly basis. Payment is due by the first of the month and must be made by check or money order. All payments must be mailed to the TennCare Bureau at the address on the premium statement.

3.2.2.3 Late payment procedures

Enrollees are given a 60-day "grace period" for late payments. If payment has not been received by the 30th day, TennCare sends a late premium notice informing the enrollee that benefits will be terminated if payment is not received. The notice includes information on the amount now due (the past and current months' premium).

If payment has not been received by the 60th day, a termination notice is sent informing the enrollee that eligibility will end in thirty (30) days. The notice includes information on how to appeal if the enrollee believes the termination is in error, as well as information on how to re-apply. Enrollees terminated for failure to pay premiums can only re-apply for and meet eligibility criteria as Medicaid eligibles. Premium arrearages in effect as of July 1, 2002, will not affect an enrollee's TennCare Standard eligibility going forward. TennCare does not allow payment plans.

If an enrollee files an appeal and is found to have been terminated in error, the enrollee will be reinstated with no break in coverage.

3.2.2.4 Income and premium changes

Enrollees must report any changes in income and family size at the time such changes occur. Income changes must be reported to the enrollee's DHS worker. Enrollees must provide a completed employer statement showing the new income. Self-employed enrollees must provide appropriate proof of income changes, such as the most recent quarterly tax statement filed with the IRS. Details regarding documents to be supplied to DHS and requirements regarding reporting of changes in information are provided in TCA 71-5-110.

The DHS worker will enter the new income information, and ACCENT (the DHS system) will recalculate the premium obligation. Changes, including a change in premiums if required, will be effective the day on which the change is reported. Changes will not be made on a retroactive basis.

Enrollees are also required to report any changes in family size. Changes must be reported to the enrollee's DHS worker. Appropriate documentation is required, as follows:

- Divorce or separation: copy of the divorce or separation papers;
- Marriage: copy of marriage license;
- Adoption or custodial arrangement for child: copy of the adoption or guardianship papers;
- Death: copy of death certificate, funeral program, or newspaper announcement;
- Removal of child (under age 19) from a case: proof the child has married or had a child.

Individuals not already eligible for TennCare can be added for the purpose of determining family size. Changes in family size may affect premium obligations. Individuals seeking TennCare coverage must complete the application and eligibility determination process.

TennCare makes an exception for newborns. Newborns should be reported to DHS. If the mother is enrolled in TennCare at the time of birth, the effective date of coverage for the newborn will be the date of birth. Parents or family representatives should proceed immediately with enumeration of the infant for Social Security Number purposes. Newborns of Medically Eligibles will be required to establish eligibility in their own category at the next family renewal interview.

3.2.3 Copays Other than Pharmacy Copays

Copays for TennCare Standard enrollees with incomes at or above 100% of poverty are similar to commercial copays and are shown in Table 8. To encourage good preventive health habits, there are no copays for preventive care visits such as well child visits, immunizations, check-

ups, pap smears, prostate examinations, and mammograms.

Table 8
Co-payment Schedules for TennCare Standard

Poverty Level	Co-payment Amounts
0%-99%	$0.00
100% - 199%	$3.00 Prescription drug (brand name) $25.00 Hospital Emergency Room (waived if admitted) $5.00 Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care $15.00 Physician Specialists (including Psychiatrists) $100.00 Inpatient Hospital Admission
200% and above	$3.00 Prescription drug (brand name) $50.00 Hospital Emergency Room (waived if admitted) $10.00 Primary Care Provider and Community Mental Health Agency Services Other Than Preventive Care $25.00 Physician Specialists (including Psychiatrists) $200.00 Inpatient Hospital Admission

Medicaid eligibles are exempt from non-pharmacy copays. Preventive services are exempt from copay obligations.

Effective August 1, 2005, there are no deductibles or annual out-of-pocket (OOP) maximums which apply to persons with copay obligations. This means that an enrollee is required to pay all copays in a given calendar year, with no limit.

Copays are due at the time of service and are collected by the health care provider.

3.2.4 Pharmacy Copays

Pharmacy copays apply to TennCare Standard children whose family income is at or above 100% of the federal poverty level, as well as non-institutionalized Medicaid adults in the TennCare project. Pharmacy copays also apply to TennCare Standard adults enrolled in the SSD program, once that program is open.

The pharmacy benefits manager (PBM) processes online, point-of-service (POS) pharmacy claims and reduces the reimbursement to the pharmacist by the appropriate copay amount. The dispensing pharmacist collects the appropriate co-payment from the member.

Effective August 1, 2005, the Pharmacy Copay amounts are as follows:

Generic	$0
Brand Name	$3

Pharmacy co-payments do not apply to family planning services, emergency services, pregnant women, institutionalized enrollees or enrollees receiving services in an HCBS program, or enrollees receiving hospice care.

There are no annual out-of-pocket (OOP) maximums which apply to pharmacy co-payments. This means that an enrollee is required to pay all pharmacy co-pays in a given calendar year, with no limits.

Part Four: Service Delivery

4.1 Overview of Managed Care Entities

4.1.1 Mainstream Managed Care Organizations

TennCare enrollees receive their physical health services from contracted MCOs. MCOs are required to maintain adequate provider networks and must meet the geoacess standards outlined in the Special Terms and Conditions of the demonstration, as well as the following minimum guidelines:

- Networks must include specified safety net providers for specified safety net services;
- Networks must include at least one Center of Excellence for people with HIV/AIDS in each of the Grand Regions in which the MCO participates;
- Networks must include Centers of Excellence identified through the state's EPSDT program for treatment of children in state custody;
- Networks must include adequate numbers of physician specialists to meet the needs of the enrolled population;
- MCOs are encouraged to contract with Federally Qualified Health Centers. If an MCO chooses not to contract with FQHCs, it must demonstrate that its network is adequate without them to insure needed capacity and range of services for vulnerable populations;
- MCOs must contract with local health departments for EPSDT screenings, until the MCO can demonstrate that it is able to meet the EPSDT screening goals without these providers.

MCOs must also maintain appropriate case management systems to ensure that enrollees receive all necessary services on a timely basis.

4.1.2 TennCare Select

In 2001, the state developed TennCare Select, a self-insured health plan administered for the state by Volunteer State Health Plan. TennCare Select currently serves the following populations:

- Children who are eligible for Supplemental Security Income;
- Children in state custody and children leaving state custody;
- Children in an institutional eligibility category (meaning eligible for care in a Nursing Facility or Intermediate Care Facility for the Mentally Retarded or an alternative to long-term care such as a Home and Community Based Services waiver);
- Enrollees temporarily residing out-of-state;
- Undocumented aliens who meet TennCare eligibility criteria and whose emergency services are paid for by TennCare in accordance with 42 CFR 440.225(c).

TennCare Select also functions as the back-up plan should one of the MCOs have to leave the TennCare project unexpectedly. The state reserves the right to add groups to TennCare Select as needed.

All TennCare Select members are assigned to a Primary Care Provider (PCP) who is responsible for providing or arranging for the provision of necessary health care services.

TennCare Select members are not required to get referrals from the PCPs for behavioral health services.

4.1.3 Behavioral Health Organizations

Since 1996, TennCare enrollees have received behavioral health services through the TennCare Partners program. Under the Partners program, contracted behavioral health organizations provide covered behavioral health services. There are presently two BHOs. Behavioral health pharmacy services continue to be carved out and provided through the state's Pharmacy Benefits Manager (PBM).

Contracts with MCOs and BHOs have been revised to be more specific regarding which services are to be covered by which entity and what mechanisms must be in place for MCO/BHO coordination.

As with the MCOs, the state requires the BHOs to meet certain minimum requirements to ensure that enrollees have appropriate and timely access to services. These requirements are contained within the BHO Contractor Risk Agreement.

Should one of the BHOs leave the TennCare project for any reason, the state will implement a contingency plan which will involve moving that BHO's members to the remaining BHO if the remaining BHO has adequate capacity and adequate financial reserves to accept the new members. Should the capacity or financial reserves of the remaining BHO not be adequate, the state would have no choice but to return to a modified fee-for-service arrangement in those areas of the state where such an arrangement is the only option. The state presented a proposed Emergency Plan to CMS in the spring of 2000 that outlined steps to be taken should it be necessary to return to such an arrangement because of the unexpected departure of one of the managed care entities. This plan, which was approved by CMS, will be used by the state if such an arrangement is necessary for the BHO project.

In March 2006, the state received CMS approval to operate with one BHO statewide. The state has not yet implemented this approval.

4.2 Organization of Managed Care Networks

4.2.1 Grand Regions and "Regions"

Grand regions are the three geographical regions into which the state of Tennessee is divided: East Tennessee, Middle Tennessee, and West Tennessee. MCOs wishing to participate in TennCare must be regionally based—that is, they must cover one of the three geographical regions. Generally, they are not permitted to cover an area that is smaller than one of the three grand regions. They are permitted to operate in more than one grand region only at the discretion of TennCare.

The three grand regions consist of the following regions, or Community Service Areas (CSAs):

- **East Grand Region:** First Tennessee, East Tennessee, Knox, Southeast Tennessee, and Hamilton Regions
- **Middle Grand Region:** Upper Cumberland, Mid Cumberland, Davidson, and South Central Regions

- **West Grand Region:** Northwest, Southwest, and Shelby Regions

"Regions" are defined geographical areas that encompass a cluster of adjoining counties. They are also called Community Service Areas (CSAs). There are 12 regions in Tennessee, and they are made up of the following counties:

East Grand Region

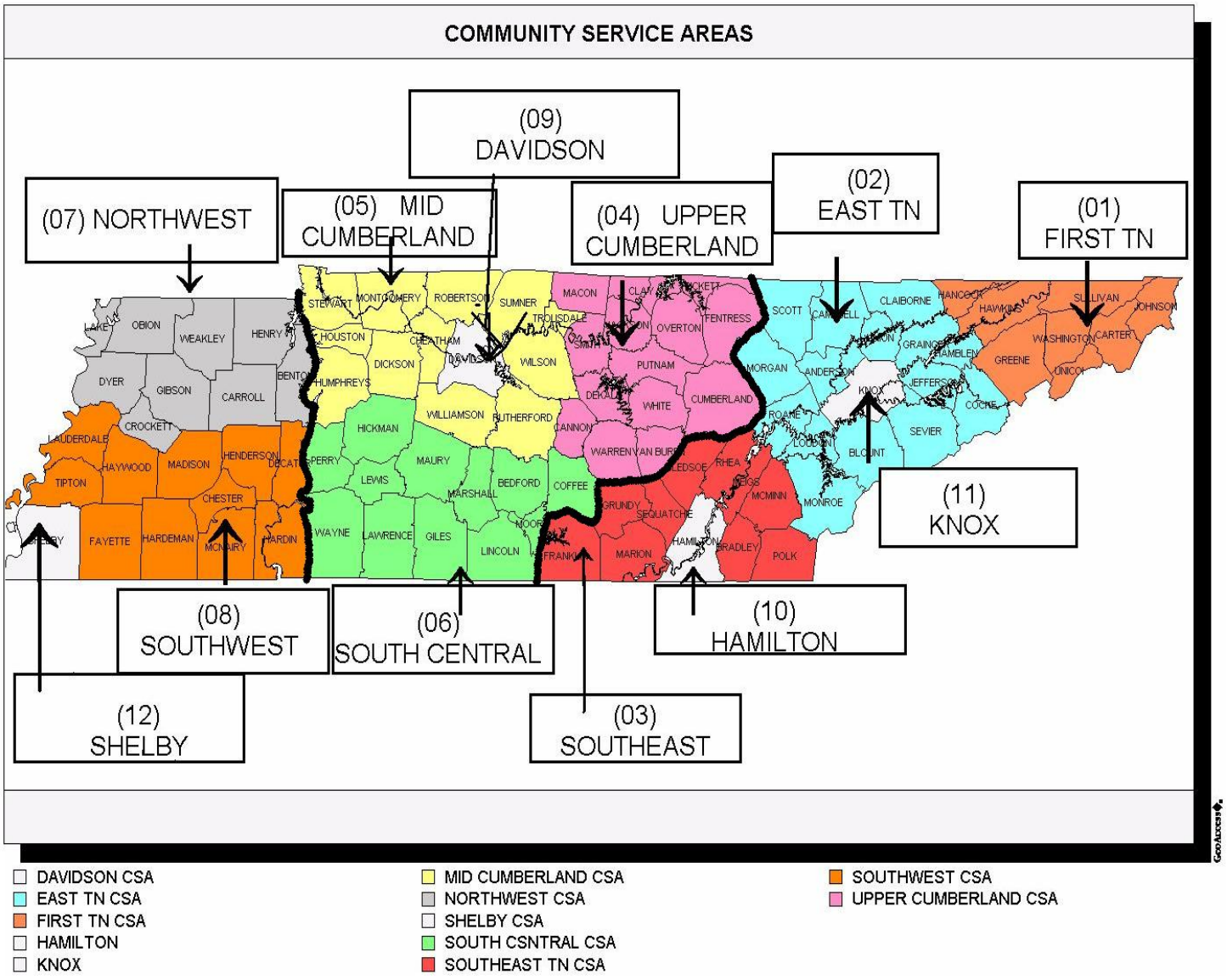
- **First Tennessee Region:** Hancock, Hawkins, Sullivan, Greene, Washington, Unicoi, Carter, and Johnson Counties
- **East Tennessee Region:** Scott, Campbell, Claiborne, Morgan, Anderson, Union, Grainger, Hamblen, Jefferson, Cocke, Sevier, Blount, Monroe, Loudon, and Roane Counties
- **Knox County Region:** Knox County
- **Southeast Tennessee Region:** Franklin, Grundy, Sequatchie, Bledsoe, Rhea, Meigs, McMinn, Polk, Bradley, and Marion Counties
- **Hamilton County Region:** Hamilton County

Middle Grand Region

- **Upper Cumberland Region:** Macon, Clay, Pickett, Smith, Jackson, Overton, Fentress, Dekalb, Putnam, Cumberland, White, Cannon, Warren, and Van Buren Counties
- **Mid Cumberland Region:** Stewart, Montgomery, Robertson, Sumner, Trousdale, Houston, Dickson, Cheatham, Wilson, Humphreys, Williamson, and Rutherford Counties
- **Davidson County Region:** Davidson County
- **South Central Region:** Perry, Hickman, Maury, Marshall, Bedford, Coffee, Wayne, Lewis, Lawrence, Giles, Lincoln and Moore Counties

West Grand Region

- **Northwest Region:** Lake, Obion, Weakley, Henry, Dyer, Crockett, Gibson, Carroll, and Benton Counties
- **Southwest Region:** Lauderdale, Haywood, Madison, Henderson, Decatur, Tipton, Fayette, Hardeman, Hardin, Chester, and McNairy Counties
- **Shelby County Region:** Shelby County



4.2.2 Selection and Contracting Process

In order for an MCO to be selected for participation in the TennCare project, it must meet all of the qualifications established in the TennCare Contractor Risk Agreement. Included in these qualifications are the following:

- Appropriate licensure as an HMO by the Tennessee Department of Commerce and Insurance;
- Demonstration of adequate financial capacity to take on risk for all contracted services and enrollees;
- Demonstration of an adequate provider network to deliver all contracted services to all enrollees in the plan in accordance with time/distance/location/patient volume standards established by TennCare;
- Demonstration of ability to offer electronic billing to providers, to comply with prompt pay processing requirements, and to use standard billing forms and formats as required by TennCare and TDCI;

- Demonstration of ability to adhere to all quality health standards, including preventive health standards, established by TennCare;
- Demonstration of ability to report provider related data using a uniform provider number, as established by TennCare.

New or start-up MCOs normally begin operating at the beginning of a TennCare contract period. New MCOs are now solicited through a competitive bidding process conducted in accordance with the State's procurement policies.

For existing MCOs, the contracting process is ongoing. Contracts are amended, renegotiated, and/or terminated in accordance with the terms outlined in the contract.

4.2.3 Benefit Packages

Both physical health services and behavioral health services are covered under TennCare. The list of these services is found in Attachment F.

4.2.4 Network Requirements

Network requirements are contained in the Special Terms and Conditions for Access (see Attachment G).

4.2.5 Mailing of Identification Cards

MCOs are required to provide identification cards to all their members to identify them as enrollees in their plan. Identification cards must be approved in writing by the state. The cards must comply with all state and federal requirements.

Members must receive cards within 30 days of their enrollment in TennCare, or sooner, if the MCO contract requires a shorter timeframe.

4.2.6 Member Service and Clinical Performance Standards

MCOs must assess member satisfaction and access to services using the Consumer Assessment of Health Plan Survey (CAHPS). In addition, MCOs are required to measure the percent of member calls not answered, including callers who hung up while waiting in the queue. The benchmark is less than 5% of calls not answered.

All MCOs are also required to report a full set of HEDIS data to the state annually. CAHPS and HEDIS performance indicators are compared to national norms and tracked over time in order to evaluate the effectiveness of quality improvement efforts. Selected HEDIS measures are described below in order to provide examples of the types of indicators that are reported.

- The percentage of children two years of age who had four DTaP/DT, three IPV, one MRR, three H influenza type B, three hepatitis B, one chicken pox vaccine (VZV0) and four pneumococcal conjugate vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates (target: 100%);

- The percentage of adolescents 13 years of age who had a second dose of MRR, three Hepatitis B and one chicken pox vaccine (VZV) by their 13th birthday. The measure calculates a rate for each vaccine and one combination rate (target: 100%);

- The percentage of women 40-69 years of age who had a mammogram to screen for breast cancer (meeting the guidelines of the American College of Obstetricians and Gynecologists);

- The percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer(meeting the guidelines of the American College of Obstetricians and Gynecologists);

- The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had each of the following (target: at least one test per year):
  - HbA1c testing
  - HbA1c poor control (>9.0%)
  - HbA1c good control (<7.0%)
  - Eye exam (retinal) performed
  - LDL-C screening performed
  - LCL-C control (100mg.dl)
  - Medical attention for nephropathy
  - Blood pressure control (<140/90 mm Hg)
  - Blood pressure control (<130/80 mm Hg)

- Children 12-24 months and 25 months and 25 months-6 years who had a visit with an MCO primary care practitioner during the measurement year (target: 100%);

- Children 7-11 and adolescents 12-19 years who had a visit with an MCO primary care practitioner during the measurement year or the year prior to the measurement year (target: 100%);

- The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery (target: 100%).

4.2.7 PCP Selection and Assignment

MCOs must provide primary care case management services to TennCare enrollees. These services include the management of medical care and continuity of care. Primary care providers may include licensed physicians as well as Advance Practice Nurses and physician assistants practicing in accordance with state law. For enrollees with complex medical problems, the MCO may choose to designate the enrollees' attending specialists as primary care providers. The PCP is responsible for maintaining enrollee medical records, for performance of reasonable preventive health services, for documenting emergency encounters and medically indicated follow-up, for coordinating hospital and/or institutional discharge planning, and for other services that may be specified in the MCO Contract.

To the extent feasible and appropriate, MCOs must offer each enrollee a choice of PCPs. They must also offer enrollees an opportunity to change PCPs within a time period of no greater than 12 months under normal circumstances. More frequent changes may be permitted when there is good cause.

4.2.8 Specialist Referrals

MCOs must assure access to specialists for the provision of covered services. Access standards for specialists are identified in the Special Terms and Conditions for Access (See Attachment G).

4.2.9 Best Practice Network (BPN)

The Best Practice Network (BPN) is composed of Best Practice Providers (BPP). A Best Practice Provider is one (primary care, behavioral health, or dental) who has been determined by the state to have the interest, commitment, and competence to provide appropriate care for children in state custody (Part 2 B), in accordance with statewide Best Practice Guidelines, and who has agreed to be in the MCO network. The BPN is currently a sub-network of TennCare Select providers. One part of the agreement is to provide a medical home for these children by maintaining all health records for the child, regardless of where the care is provided. All providers are required to forward medical records to the BPN PCP so that a comprehensive medical record can be maintained.

4.2.10 Appointment Timeliness Standards

Appointment timeliness standards are as stated in the Special Terms and Conditions for Access (See Attachment G).

4.2.11 Claims Systems and Performance Standards

MCOs are required to have in place an automated claims payment system capable of accepting and processing claims submitted electronically, with the exception of certain claims that require written justification for payment (such as hysterectomy consent forms). The MCO must assure that 90% of clean claims for payment of services delivered to a TennCare enrollee are processed within 30 days of receipt of the claim. (A clean claim is defined as one for which no further written information or substantiation is required in order to make a decision on payment.) In addition, the MCO must assure that it adjudicates 99.5% of claims within 60 days of receipt. The MCO is required to contract with independent reviewers to review disputed claims in accordance with Tennessee Code Annotated, Section 56-32-226.

MCOs are required to measure their claims payment accuracy, based upon the number of claims paid accurately upon initial submission. The target is 100%, with a benchmark of 97% accuracy upon initial submission.

4.3 Payment Mechanisms

4.3.1 MCC Reimbursement Methodology

4.3.1.1 Managed Care Organizations (MCOs)

Payments to most MCOs fall into two general categories: Administrative and Medical Reimbursement. Administrative payments are made to each MCO monthly by the TCMIS based on the number of enrollees that MCO served during the month. Payments are also made to MCOs for reimbursement of actual medical expenses incurred by TennCare enrollees on a weekly basis.

A portion of the MCOs Administrative payment is placed at risk. The terms of this arrangement include a Risk and Bonus component, placing ten percent (10%) of the administrative fee at risk and providing a Bonus potential to earn fifteen (15%) of the administrative fee for maintaining and/or meeting specified performance measures. The performance measures and percentages of Risk or Bonus associated with each are listed below:

Shared Risk Initiative	Contribution to Risk	Contribution to Bonus
Medical Services Budget Target	2.0%	5.0%
Usage of Generic Drugs	2.0%	2.0%
Completion of Major Milestone for NCQA	2.0%	Not Applicable
EPSDT Compliance	2.0%	2.0%
Non-Emergency ER Visits per 1000	1.0%	2.0%
Inpatient Admissions per 1000	1.0%	4.0%

For the most part, the performance measures are benchmarked against each individual MCO's previous experience and failure to maintain or improve will impact the MCO financially. Should an MCO meet benchmarks that achieve bonus payouts, the savings realized by TennCare will more than pay for the bonus payouts.

TennCare Select is not a member of the shared risk initiative.

Reimbursement for the two new MCO plans, starting April 1, 2007, in the Middle Grand Region is on a per member per month capitation basis. The rates vary by age and eligibility category. An additional capitation payment is made for enrollees designated as SPMI/SED in the last 12 months. This relates to the fact that these two MCOs are responsible for the mental health and substance abuse services for their enrollees along with their medical care. There is also a rate for people enrolled through the "State Only" services or judicial programs at TDMHDD which is paid for with only state funds.

4.3.1.2 Behavioral Health Organizations (BHO)

Unlike payments to the MCOs, payments to BHOs are not made for actual medical costs, but are made using capitation rates based on actuarial review by Aon consulting. These rates are divided into age categories and priority status for each region of the state. The contractor is paid a monthly capitation payment based upon the rates and the enrollment of the plan. This amount is calculated using the enrollee number of days for the current month and an adjustment for prior periods is made to this amount.

4.3.1.3 Dental Benefits Manager (DBM)

Payments to the DBM are similar to those made to the MCOs in that they also fall into two categories: Administrative and Medical Reimbursement. Administrative payments are made monthly based on a contracted amount per person per month.

Payments are made on a biweekly basis for reimbursement of actual dental expenses incurred by TennCare enrollees.

4.3.1.4 Pharmacy Benefits Manager (PBM)

Payments to the PBM fall into one of the following categories: Administrative, Prescription, Implementation or Call Center.

Payments made pursuant to the Administrative category are made monthly based on set fixed amounts for various administrative functions. Payments in the Prescription category are made monthly based on actual costs for prescriptions issued to TennCare enrollees. Payments in the implementation category are made monthly based on specific milestones within the PBM contract. The last category, Call Center, is for payments made to the PBM based on call center volume.

4.3.2 Payment Methodologies for Other Selected Providers

4.3.2.1 Federally Qualified Health Centers reimbursement methodology

As specified in each MCO contract, MCOs reimburse Federally Qualified Health Centers (FQHCs) either on a capitated (risk) basis considering adverse selection factors or on a cost-related basis. MCOs are also required, on at least an annual basis, to identify and report to the TennCare Bureau each FQHC with which the MCO contracts and the methodology under which the FQHC is reimbursed.

Within 60 days after the end of each quarter, FQHCs report the number of actual visits and the corresponding MCO payments for services provided to TennCare enrollees. Upon review of these reports by the Comptroller's Office, the State makes quarterly payments to the FQHCs for the actual difference between the amount of MCO reimbursements received and the adjusted prospective payment rate for the FQHCs. In the event an FQHC does not timely report the number of visits and MCO payments received for the quarter, the State will make an estimated quarterly payment and reconcile the difference once the actual data for the quarter is received.

4.3.2.2 Methodology for Essential Access Hospital payments

4.3.2.2.1 Eligible hospitals

Hospitals eligible to receive essential access hospital payments include all hospitals licensed to operate in the State of Tennessee excluding the five (5) state mental health institutes and the critical access hospitals. The critical access hospitals receive cost-based reimbursement from the TennCare project and therefore are not eligible for EAH pool payments.

4.3.2.2.2 Allocation of the pool to segments of hospitals

The $100 million pool is segmented into four distinct parts as follows:

- **Essential Service Safety Net hospitals - $50 Million**

  These hospitals are defined as any hospital that is both a Level 1 Trauma Center and a Regional Perinatal Center or any metropolitan public hospital that is contractually staffed and operated by a safety net hospital for the purpose of providing clinical education and access to care for the medically under served.

- **Children's Safety Net hospitals - $5 Million**

These hospitals are defined as any hospital licensed by the Tennessee Department of Health whose primary function is to serve children under the age of 21 years in Tennessee.

- **Free Standing Psychiatric hospitals - $2 Million**

These hospitals are defined as hospitals licensed by the Tennessee Department of Mental Health and Developmental Disabilities for the provision of psychiatric hospital services in Tennessee excluding the State Mental Health Institutes.

- **Other Essential Acute Care hospitals - $43 Million**

These hospitals include all other hospitals licensed by the Tennessee Department of Health to provide services in Tennessee excluding the critical access hospitals and state mental health institutions.

4.3.2.2.3 Data

Calculation of the quarterly payments is based on the most current Joint Annual Report of Hospitals available at the beginning of the state fiscal year for which the quarterly payments are being made.

4.3.2.2.4 Minimum qualifications

All hospitals, other than free standing psychiatric hospitals, must be contracted providers with TennCare Select and, where available, at least one other Managed Care Organization in the TennCare project. In order to receive a payment, the free standing psychiatric hospitals must be a contracted provider with at least one of the Behavioral Health Organizations in the TennCare project. All hospitals (unless they are capitated and accept the capitation as full reimbursement) must have unreimbursed TennCare cost.

Minimum qualification for all acute care hospitals:
Each qualifying hospital must have 13.5% or more of its total adjusted days covered by TennCare.

- OR -

A hospital may qualify if 9.5% or more of the total adjusted days are covered by TennCare and the number of adjusted days for the hospital is higher than the average number of TennCare Adjusted Days.

Minimum qualifications for Freestanding Psychiatric hospitals
At least 30% of total adjusted days are covered by TennCare.

4.3.2.2.5 Allocations and calculation of points

Allocation is based on an assignment of points for:

- TennCare adjusted days expressed as a percent of total adjusted patient days;
- Bad debt, charity, and medically indigent care expressed as a percent of total expenses.

Calculation of points

(1) TennCare volume is defined as the percent of a hospital's total adjusted days that are covered by TennCare. Points are assigned based on that percent as follows:

- 1 point – greater than or equal to 9.5% but less than 13.5% and the actual number of TennCare adjusted days must be greater than the average for all acute care hospitals, excluding the critical access, pediatric and safety net providers;
- 1 point – greater than or equal to 13.5% and less than or equal to 24.5%;
- 2 points – greater than 24.5% and less than or equal to 34.5%;
- 3 points – greater that 34.5% and less than or equal to 49.5%;
- 4 points – greater than 49.5%.

(2) Bad debt, Charity and Medically Indigent – BDCHMI costs as a percent of total expenses

- 0 points – less than 4.5%
- 1 point - greater than or equal to 4.5% and less than 9.5%
- 2 points - greater than or equal to 9.5% and less than 14.5%
- 3 points - greater than or equal to 14.5%

4.3.2.2.6 Calculation of amounts of payments for hospitals

These points are then used to adjust the General Hospital Rate (GHR) based on pre-TennCare hospital reimbursement rates. The GHR rate includes all inpatient costs (operating, capital, direct education) but excludes add-ons (indirect education, MDSA, return on equity).

The GHR for Safety Net Hospitals is $908.52. The GHR for Other Essential Access Hospitals is $674.11. The points for each qualifying hospital are summed and then used to determine the percent of the GHR that is used to calculate the initial payment amount for each hospital.

- 7 points – 100% of GHR
- 6 points – 80% of GHR
- 5 points – 70% of GHR
- 4 points – 60% of GHR
- 3 points – 50% of GHR
- 2 points – 40% of GHR
- 1 point – 30% of GHR

For each of the four pools, the appropriately weighted GHR for each qualifying hospital is multiplied by the number of adjusted TennCare days provided by the hospital. These amounts are summed for all of the hospitals that qualify for the pool. Each hospital's initial calculated amount is then adjusted to the total in the pool. This is done by multiplying the initial calculated amount for a hospital by the ratio of the total initial calculated amount for all qualifying hospitals to the total amount of the pool allocated for that group. So if the sum of the initial calculated amounts for the pediatric group is $9 million and the total pool for children's hospitals is $5 million, each hospital's initial calculated amount will be multiplied by $5 million / $9 million. The resulting values will be the amounts to be provided to the hospitals as an essential access hospital payment for the fiscal year.

4.3.2.2.7 Payments

Hospitals are paid on a quarterly basis following the end of each quarter. The initial payment includes all quarters that have ended at the time that the payment is made. All subsequent

quarterly payments are made following the end of the quarter. In order to receive a payment for the quarter, all non-free standing psychiatric hospitals must be a contracted provider with TennCare Select and, where available, at least one other Managed Care Organization, and must have contracted with TennCare Select for the entire quarter that the payment represents. In order for the free-standing psychiatric hospitals to receive a payment for the quarter, the free-standing psychiatric hospitals must be a contracted provider with at least one of the Behavioral Health Organizations.

4.3.2.2.8 Disproportionate Share payments

On December 21, 2006, Tennessee submitted a State plan amendment (SPA) to revise the payment methodology for inpatient hospital services to implement a one-year disproportionate share hospital payment distribution in accordance with the Tax Relief and Health Care Act of 2006. The SPA was approved by CMS on March 21, 2007.

Under the SPA, hospitals are grouped into five categories:

Group 1: Essential Service Safety Net hospitals
Group 2: Children's Safety Net hospitals
Group 3: Free Standing Psychiatric hospitals
Group 4: Other Essential Acute Care hospitals
Group 5: All other DSH hospitals as defined by Section 1923(b) of the Social Security Act but not qualifying in one of the above groups

Hospitals will receive payments that vary according to the group in which they are categorized and factors such as TennCare volume and bad debt, charity, and medically indigent care. Payments under the Essential Access pool (see section 4.3.2.2.2) will be adjusted and the total DSH payment will be approximately $131 million.

4.3.3 Special Pool Payments to Critical Access Hospitals

In accordance with the Special Terms and Conditions, the state shall make special pool payments to TennCare Critical Access Hospitals. The state's methodology for making these payments and for claiming federal participation for the payments is described below.

To qualify for payment as a Critical Access Hospital, a hospital must meet the following criteria:

- It must be an acute care hospital located and licensed in the State of Tennessee.
- It must be designated as a Critical Access Hospital by the Tennessee Department of Health.
- It must contract with a managed care organization participating in TennCare.

TennCare provides reimbursement to Critical Access Hospitals under the following terms. Payments are limited to specific legislative appropriations for which federal financial participation is available. In any fiscal year where reimbursable TennCare costs incurred by Critical Access Hospitals exceed annual appropriations, equitable adjustments are made to the rates described below to cap reimbursement at the annual appropriation for which federal financial participation is available. Payments to hospitals are made through a contractual agreement with a TennCare managed care organization.

Inpatient Critical Access Hospital services include no more than 15 acute inpatient beds, although an exception to the requirement is made for swing bed hospitals. Critical Access Hospitals are allowed to have up to 25 inpatient beds that can be used interchangeably for acute or Skilled Nursing Facility (SNF) level of care, provided that no more than 15 beds are used at any one time for acute care.

Inpatient services. Effective for dates of service beginning July 1, 2002, TennCare inpatient services that are furnished by Critical Access Hospitals are reimbursed quarterly with interim per diem rates and are cost-settled at year-end. Using the Joint Annual Reports filed for the most recent year available, interim per diem rates for TennCare inpatient services are determined with consideration given to payments for TennCare services made to hospitals by managed care organizations and any special payments to hospitals. Interim rates are calculated to reimburse hospitals at a rate that will not exceed 95% of TennCare reasonable costs.

Outpatient services. Effective for dates of service beginning July 1, 2002, TennCare outpatient services that are furnished by Critical Access Hospitals will be reimbursed based on a percentage of charges with year-end cost settlements. Using the Joint Annual Reports filed for the most recent year available, interim rates for TennCare outpatient services will be determined as a percentage of charges with consideration for payments for TennCare services made to hospitals by managed care organizations and any special payments to hospitals. Interim rates will be calculated to reimburse hospitals at a rate that will not exceed 95% of TennCare reasonable costs.

For new Critical Access Hospitals that qualify after July 1, 2002, the state began reimbursement at the rates established on the first day of the calendar month after notification to the Bureau of TennCare by the hospital of its Critical Access Hospital designation. At that time, interim rates were established, and the designation was confirmed with the Department of Health.

Each Critical Access Hospital is required to maintain adequate financial and statistical records which are accurate and in sufficient detail to substantiate the cost data reported. These records must be retained for a period of not less than five years from the date of the submission of the Joint Annual Report. The provider is required to make such records available upon demand to representatives of the Bureau of TennCare or the United States Department of Health and Human Services. All hospital cost reports and Joint Annual Reports are subject to audit at any time by the Comptroller of the Treasury and the Bureau of TennCare or their designated representative.

4.3.4 Supplemental Pool Payments to Meharry Medical College

Under the Medicaid Section 1115 demonstration, Special Terms and Conditions, TennCare makes supplemental payments to Meharry Medical College's clinics based on the unreimbursed TennCare costs incurred by these entities.

TennCare provides federal matching funds for the Meharry Medical College state operating grant at the current rate of federal financial participation subject to available state appropriations, TennCare budget neutrality under the demonstration, and TennCare unreimbursed costs incurred by Meharry's clinics. The annual amount is allocated and paid on a regular basis to one of the Meharry Medical College clinics.

Each of the clinics operated by Meharry Medical College must contract with a managed care organization and/or behavioral health organization participating in TennCare.

Meharry provides an annual analysis of unreimbursed TennCare costs incurred by the clinics. This analysis is subjected to certain agreed-upon procedures determined by TennCare and Meharry Medical College and applied by a certified public accountant to ensure costs and related revenues are accurately reflected in the analysis. The analysis takes into consideration all revenue received for the TennCare services provided, including revenue from supplemental

TennCare payments and from the Metropolitan Government of Nashville and Davidson County through a professional services agreement.

The college and its clinics are required to maintain adequate financial and statistical records, which are accurate and in sufficient detail to substantiate the cost and revenue data reported. These records must be retained for a period of not less than five years from the date of the submission of the unreimbursed cost analysis. The provider is required to make such records available upon request to representatives of the Bureau of TennCare or the United States Department of Health and Human Services. All reports are subject to audit at any time by the Comptroller of the Treasury and the Bureau of TennCare or their designated representative.

4.3.5 Special Pool Payments for FY 2006

All hospitals licensed to operate in Tennessee, excluding the state mental health institutions and the critical access hospitals, were eligible to receive a special hospital pool payment approved by CMS on March 31, 2006. The critical access hospitals receive cost-based reimbursement from the Section 1115 demonstration program and therefore do not have any unreimbursed TennCare costs. This special pool payment was done in two installments in June 2006. It was segmented into four distinct parts as follows:

- Essential Service Safety Net - $25 million
- Children's Safety Net - $2.5 million
- Free Standing Psychiatric Hospitals - $1 million
- Other Essential Acute Care - $21.5 million

4.4 Encounter Data

4.4.1 Overview

This chapter describes encounter data reporting requirements for MCOs, BHOs, TennCare Select, the Pharmacy Benefits Manager and Dental Benefits Manager. Each of these Managed Care Contractors (MCCs) is required to submit individual encounter records on a regular basis for services provided to TennCare eligibles. Encounter data is required in order to monitor quality of care, monitor service utilization and cost trends, support rate-setting, and satisfy federal reporting requirements (see Part 6).

4.4.2 Systems requirements

To ensure the timely submission of accurate encounter data, all TennCare MCCs are required to maintain and operate an information system capable of capturing individual units of service interfacing with the TennCare MMIS. All vendors must successfully complete a readiness review of their information systems that is designed to ensure that their processing system satisfies the functional and informational requirements of TennCare. Each vendor has an access network established with TennCare for sharing data. Any software or additional communications network required for access is provided by the MCCs. To ensure the timely capture and reporting of data TennCare MCCs must process 99.5% of claims within 60 days of receipt. The TennCare interface standard for data transfers is via FTP, using HIPAA transaction formats, with DVDs, CDs or 36 track compressed cartridges for backup contingency, initial file loads and TennCare selected communications.

4.4.2.1 Frequency

All MCCs (MCOs, BHOs, DBM, and PBM) participating in TennCare are required to submit individual encounter data generated in the process of their regular financial cycle, typically on a weekly basis. Individual encounter records for hospital, home health, professional, community health clinic services, ambulance services, dental services, pharmacy services, hospice services, and other medical services are required.

4.4.2.2 Format

To support the uniform reporting of encounter data all MCCs are required to utilize standardized claim formats. The required formats are:

Type of Claim	**Required Format**
Professional	ASC X12N 837P
Institutional	ASC X12N 837I
Dental	ASC X12N 837D
Pharmacy	NCPDP 1.1

Once claims for payment are processed, MCCs must submit encounters for individual units of service to TennCare. Generally MCC encounter files are generated as part of the standard financial cycle and submitted to TennCare, most often being received and processed concurrent with or shortly following issuance of a check from the MCC. For the MCO and BHO, required minimum data elements for encounter reporting are included in the Contractor Risk Agreement. The critical data elements for the pharmacy and dental programs are included in the contracts with the Pharmacy and Dental Benefits Managers.

4.4.2.3 Data integrity

Upon receipt of encounter data files, TennCare conducts several validation edits ranging from verifying that financial fields have numeric characters to verifying that required fields, such as individual identifiers (e.g., Patient Last Name, ID Number), are populated. Any error that results in a HIPAA compliance edit results in the rejection of the entire file. All seven levels of HIPAA reporting compliance are validated. In the event that edits identified as threshold edits are greater than 2%, the entire file is also rejected. The MCC is usually given 3 business days to submit a replacement file. In the unlikely event that an MCO does not comply with encounter data reporting requirements, TennCare may apply liquidated damages or other intermediate sanctions as specified in the Contractor Risk Agreement.

Part Five: Quality of Care

5.1 Quality Assurance and Utilization Review

5.1.1 MCO Quality Monitoring

The Division of Quality Oversight is responsible for monitoring and ensuring that TennCare members have access to timely, appropriate, high quality, medically necessary, covered healthcare services and experience quality health outcomes. Monitoring activities are either provided directly by Quality Oversight or in concert with TennCare contractors.

TennCare has mandated that all Managed Care Organizations (MCOs) participating in the TennCare Project be accredited by the National Committee for Quality Assurance (NCQA) by December 31, 2006. NCQA accreditation was selected because the accreditation survey process encompasses a comprehensive review of the key aspects of care and service and the overall quality of care provided by individual MCOs. The contracts of Managed Care Organizations failing to obtain NCQA accreditation, by December 31, 2006, were to be terminated by the Bureau of TennCare, leaving only those MCOs providing the highest quality of care and service to serve the TennCare population.

As part of the accreditation process, the MCOs performed the Medicaid version of the Health Plan Employer Data and Information Set (HEDIS) and the Consumer Assessment of Health Plans Study (CAHPS Survey). HEDIS and CAHPS will allow a reliable comparison of the performance of TennCare MCOs to other Medicaid managed care health plans.

HEDIS data is audited by a NCQA certified HEDIS auditor prior to submission to TennCare and NCQA. This data allow TennCare to assess MCO specific performances and perform comparative analyses of TennCare to other Medicaid managed care plans throughout the country. This data will be used to identify best practices and determine opportunities for improvement among the TennCare MCOs.

The CAHPS survey tool measures health care consumers' satisfaction with the quality of care and customer service provided by their health plans. Audited HEDIS and CAHPS data is required to be submitted to TennCare annually for review and analysis. MCOs are required to report NCQA Accreditation findings, level of accreditation awarded by NCQA and any changes in accreditation status to TennCare.

5.1.2 Network Access

MCOs must assure that there are an adequate number of primary care providers, specialists and other service providers who are willing and able to provide the level of care and range of services necessary to meet the medical needs of the members enrolled in their Plan. The MCOs and the Dental Benefits Manager must demonstrate their ability to provide all contracted services on a timely basis and assure accessibility to services. There are certain time/distance travel standards outlined in the Contractor Risk Agreements that must be met. The Provider Networks Unit evaluates MCO and DBM provider networks on a routine basis and, where non-compliance is indicated, a corrective action plan is requested.

5.1.3 BHO Quality Monitoring

The Tennessee Department of Mental Health and Developmental Disabilities' (TDMHDD) Office of Managed Care (OMC) is charged with monitoring and oversight of the Behavioral Health Organizations (BHOs) participating in the TennCare Partners Program. The TennCare Bureau has also contracted with the TDMHDD to assess the effectiveness of the use of clinical best practice guidelines for adults and children receiving services through the TennCare Partners Program, and assessing the use of these best practices for children in the custody of the Tennessee Department of Children's Services (DCS) when the behavioral health services are rendered by DCS contracted providers. The Office of Managed Care shall routinely assess that these individuals are receiving medically necessary behavioral health services in accordance with these guidelines.

The Office of Managed Care's Performance Monitoring Plan details the components of monitoring and oversight that will be implemented to ensure contractual compliance, assess and promote the delivery of quality and timely mental health services, and to provide structure and means for communicating issues and outcomes to all appropriate entities. The Performance Monitoring Plan includes monitoring activities such as scheduled site visits, required BHO contract deliverables, and special focus studies targeting improvement in relevant areas of clinical care and non-clinical services.

5.1.4 External Quality Review Organization (EQRO) Activities

TennCare contracts with an EQRO to support independent, external reviews of the quality of services available to enrollees in the TennCare project. The EQRO assists the Bureau of TennCare in reaching its goal of ensuring that each enrollee can access timely, high quality, medically necessary, covered healthcare services.

The EQRO provides services that are consistent with the following:

- Applicable Federal External Quality Review (EQR) regulations and protocols for Medicaid Managed Care Organizations,
- State specific requirements related to Federal court orders, including *Grier*, *John B,* and *Newberry*; and
- Contractor Risk Agreements (CRA) with TennCare Managed Care Contractors including the Managed Care Organizations, Behavioral Health Organizations, and the Dental Benefits Manager.

5.1.5 EPSDT Focused Efforts

The state is taking a number of steps to improve the provision of EPSDT screenings and services. MCOs participating in TennCare must conduct effective outreach and education programs; provide transportation and scheduling assistance for each eligible child's periodic examination; and conduct extensive provider education.

EPSDT screens are to be provided in accordance with the latest "American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care" periodicity schedule. Annually, the Division of Quality Oversight monitors the MCOs' performance with respect to the provision of EPSDT screens and a statistically valid sample of medical records is reviewed to measure whether or not the seven (7) required components of the screen have been performed.

MCOs are required to submit corrective action plans to address deficiencies found in any of the required screening components.

Specific performance targets have been established for EPSDT screens and incentives have been included in the CRA to encourage and maintain compliance with the performance targets.

5.2 Grievance and Appeal Policies

5.2.1 Eligibility Appeals

TennCare enrollees may appeal actions affecting their TennCare eligibility. Action is defined as a termination, suspension or reduction of Medicaid eligibility. Individuals applying for TennCare may appeal denials of their applications for TennCare.

The Bureau of TennCare has delegated to DHS the authority to make eligibility-related determinations, including taking final administrative action in the context of eligibility-related appeals. Prior to January 2005, appeals related to TennCare Medicaid eligibility were processed by the Department of Human Services (DHS) and appeals concerning TennCare Standard eligibility were processed by the Bureau of TennCare. Effective January 2005, however, a new Division of Appeals and Hearings within DHS assumed responsibility, utilizing a single administrative process, for both TennCare Medicaid and TennCare Standard eligibility-related appeals. TennCare, as the Single State Agency, retains the authority for final decision-making on appeals.

CMS has approved a notice and appeals process for (i) the disenrollment of adult TennCare Standard enrollees and adult non-pregnant Medically Needy enrollees at the end of their year of eligibility (summarized in Attachment E to the Special Terms and Conditions) and (ii) the initial implementation of changes in coverage of TennCare benefits (summarized in Attachment F to the Special Terms and Conditions). Based on these approved processes and in accordance with applicable federal requirements, TennCare has implemented the following structure for eligibility-related appeals:

- When an enrollee's eligibility for TennCare is terminated, suspended or reduced, individuals are provided at least 20-days advance notice. This notice informs the enrollee of (i) the reason for the action, (ii) the legal basis for the proposed action, (iii) the right to request a fair hearing, and (iv) the right to request continuation of benefits. Enrollees are provided 40 days from the date of the notice to request a fair hearing. Enrollees who request a fair hearing prior to the date of action will retain their TennCare benefits pending a determination that the enrollee has not raised a valid factual dispute or until the appeal is otherwise resolved, whichever comes first.

- When an individual's application for TennCare is denied, individuals are provided notice. This notice informs enrollee of (i) the reason for the denial, (ii) the legal basis for the denial, and (iii) the right to request a fair hearing. Individuals are provided 40 days from the date of the notice to request a fair hearing.

- Requests for fair hearings are only granted for those individuals who have raised a valid factual dispute related to the action taken by the state. DHS is responsible for reviewing each request for a hearing to determine if it is based on a valid factual dispute. If DHS

determines that there is no indication of a valid factual dispute, DHS will send the individual a letter asking him to submit additional clarification of any issue of factual dispute on which the appeal is based within 10 days. Unless such clarification is timely received and is determined by DHS to establish a valid factual dispute, DHS will dismiss the request for a fair hearing. If DHS determines that the individual has requested a hearing based on a valid factual dispute, the case proceeds to a fair hearing.

- When an appeal is scheduled for a hearing, DHS's Office of General Counsel provides the enrollee a written Notice of Hearing. The Notice of Hearing identifies the time and location of the hearing, informs the enrollee of his right to be represented by counsel along with a statement of the legal authority under which the hearing will be held and a short statement of the position asserted by DHS. Enrollees may represent themselves at the hearing or may retain someone to represent them at the hearing. Free or low-cost representation is often available from the local Legal Services Office. DHS provides the enrollee with a list of all Legal Services offices throughout the State of Tennessee.

5.2.2 Service and Benefit Appeals

TennCare enrollees have the right to appeal adverse actions affecting their TennCare benefits. Adverse actions include but are not limited to, delays, denials, reductions, suspensions or terminations of TennCare benefits as well as any other act or omission of the TennCare program which impairs the quality, timeliness or availability of such benefits. The Bureau of TennCare is responsible for processing service-related appeals.

The appeals processes developed by the Bureau of TennCare are based upon federal law, the notice and appeal processes approved by CMS for changes in coverage of TennCare benefits (summarized in Attachment F to the Special Terms and Conditions) and the provisions of applicable court orders. Notice and appeal processes include but are not limited to:

- When an adverse action is taken affecting TennCare benefits by the state, managed care entities or providers, enrollees are provided with a notice of appeal rights. The timing of the notice depends on the nature of the adverse action. For example, notice is provided to enrollees upon denials of payment for claims for services that have exceeded applicable benefit limits.

- The notice of appeal informs enrollees of (i) the type and amount of services at issue, (ii) a statement of reasons for the proposed action, (iii) the legal basis for the proposed adverse action, (iv) the right to request a fair hearing, including the right to request an expedited appeal and (v) if applicable, the right to continuation of services pending appeal. Enrollees have 30 days from the date of the notice to request a fair hearing. In circumstances when enrollees have a right to request continuation of benefits, benefits will be continued if the enrollee requests a fair hearing prior to the date of the adverse action.

- Requests for fair hearings are only granted for those individuals who have raised a valid factual dispute related to the adverse action. The TennCare Solutions Unit (TSU) will review each request for a hearing to determine if it is based on a valid factual dispute. If the enrollee fails to establish a valid factual dispute, TSU will dismiss the request for a fair hearing. If TSU determines that the individual has requested a hearing based on a valid factual dispute, the case proceeds to a fair hearing.

- When a medical service appeal is scheduled for a hearing, TennCare's Legal Solutions Unit of the Member Services Division provides the enrollee a written Notice of Hearing. The

Notice of Hearing identifies the time and location of the hearing, informs the enrollee of his right to be represented by counsel along with a statement of the legal authority under which the hearing will be held and a short statement of the position asserted by TennCare. Enrollees may represent themselves at the hearing or may retain someone to represent them at the hearing. Free or low-cost representation is often available from the local Legal Services Office. TennCare provides the enrollee with a list of all Legal Services offices throughout the State of Tennessee.

Part Six: Administration

6.1 Administration and Management Systems

6.1.1 Overview

This chapter provides a description of the TennCare Management Information System (TCMIS), including a discussion of the system design and explanation of how the system interfaces with outside agencies and providers. In addition, this chapter will describe HIPAA compliance activities that have been completed and those scheduled to be completed during the course of the new demonstration.

The Bureau recently completed implementation of a new TCMIS. The TCMIS is maintained and operated by an outside contractor, performing as the facilities manager. The new TCMIS brings increased flexibility to better support project management as well as TennCare demonstration and reform modifications, such as multiple benefit plans and carve-out programs.

6.1.2 Information System Modules

The replacement TCMIS is designed to meet the complex management and information needs of TennCare and has the capability to administer multiple benefits packages. This functionality is necessary to manage benefits service limits and optional benefit riders (e.g. optional dental benefits and pharmacy benefits only). The replacement TCMIS also automates many existing processes, such as imaging of letters generated to recipients and providers. The new system also includes accounting functions to provide for premium collections and client reimbursement for premium and out of pocket refunds.

A description of the replacement TCMIS major functions is provided below.

6.1.2.1 Eligibility

The TCMIS houses the master eligibility file for TennCare. This sub-system maintains and updates day-specific eligibility information for the TennCare Medicaid and TennCare Standard populations, as well as for SSI populations, including Medicare beneficiaries. Updates to the TennCare eligibility master file are currently received from multiple sources: DHS, DOH, DCS, SSA, DMRS and DMHDD. The eligibility subsystem is used for all functions that require eligibility and enrollment data (e.g., claims processing, enrollment processing, capitation payments, and premium collections). The system's maintenance function is to accept and maintain accurate, current and historical source data of eligibility information.

The major eligibility and enrollment functions of the TCMIS are:

- Establish and maintain a single client identifier for each person that can be associated with historical identifiers and other family members.
- Track all categories of eligibility, with begin and end dates for each category.
- Manage acceptance of Medicare, TennCare Medicaid and TennCare Standard eligibility records and updates from internal and external agencies.
- Process eligibility and maintenance updates from DHS, DCS, DMHDD, DMRS, and SSA, maintaining historical eligibility data from each.

- Use eligibility information for notice generation for re-certifying eligibility for the TennCare Standard population annually or upon a qualifying event, if needed.
- Process MCO/BHO/PBM/DBM enrollment/disenrollment.
- Assign enrollees to a Managed Care Contractor and generate MCO/BHO/PBM/DBM enrollment rosters.
- Support the balloting process, if required, to allow enrollees an opportunity to change their managed care contractor. This includes the design, printing, mailing and processing of returned ballots, should the state opt to use a ballot process in the future.
- Assure that demographic information is maintained and identifiable by data source.
- Identify persons with special needs or in special populations.
- Collect and distribute third party liability information.

The eligibility and enrollment sub-system accepts the following eligibility data:

- TennCare Medicaid and TennCare Standard eligibility data from the Department of Human Services ACCENT system.
- Presumptive eligibility for pregnant women from the Department of Health.
- Patient liability information from DHS and long term care facilities.
- SSI eligibility data from the Social Security Administration.
- DCS immediate eligibility data from the Department of Children's Services (TnKIDS system).
- Breast and Cervical Cancer Treatment eligibility data from the Department of Human Services.
- Severely and/or Persistently Mentally Ill (SPMI) and Seriously Emotionally Disturbed (SED) Eligibility data from the Tennessee Department of Mental Health and Developmental Disabilities (MHDD).
- Buy-In eligibility data from the Centers for Medicare and Medicaid Services.

This subsystem will also interface with the federal Department of Defense, Managed Care Organizations, Behavioral Health Organizations, Pharmacy Claims Processor, Dental Benefits Manager, and the Beneficiary Data Exchange to obtain enrollee information regarding third-party resources, Medicare benefits and buy-in eligibility, and External Quality Review Organizations.

6.1.2.2 Encounter Data Processing

The encounter data subsystem collects, validates and processes encounter data submitted by Managed Care Organizations, Behavioral Health Organizations and the state's Pharmacy and Dental Benefit Managers. These contractors must transfer applicable encounter data files to TCMIS using ASC X12N and NCPDP formats.

TCMIS validates the accuracy of CPT codes, HCPCS codes, Revenue Codes, ICD-9-CM codes and ADA-CDT codes. All encounter data also goes through several edit processes: including all seven levels of HIPAA compliance testing and additional edits for content and duplication.

6.1.2.3 Claims Processing

The TCMIS has the capacity to receive, track and process paper or electronic claims. TCMIS adjudicates claims from: Skilled Nursing Facilities for Level I Nursing Facility claims and Level 2 Nursing Facility claims, the Division of Mental Retardation Services for MR provider payments, Home and Community Based Services Waiver Providers, DCS, Commission on Aging, ICF/MR claims, and the Medicare Intermediary for Medicare professional cross-overs and Medicare institutional cross-overs claims. The new system receives and translates claims in accepted HIPAA transaction formats.

6.1.2.4 Enrollee Premium Payments

The Bureau of TennCare generates premium statements to certain enrollees eligible under TennCare Standard. The premium amount is based on income (Federal Poverty (FPL) criteria), family size and composition. Premium payments are collected via a lock box operation and are posted to enrollee accounts as payments are received.

Upon acceptance of an eligibility record for a TennCare Standard applicant, TCMIS will generate a notice indicating the amount of premium that the applicant is required to pay, the effective date of coverage and the payment due date. If the initial payment is not received, enrollees are sent two delinquent notices, and termination of eligibility will ultimately occur if the enrollee is more than two months in arrears. Once the initial premium payment is paid, monthly invoices will be generated. Enrollees who have obtained eligibility and who are required to pay a monthly premium are sent two delinquent notices if payments are not received on time, and termination of eligibility will ultimately occur if the enrollee is more than two months in arrears. Since one of the eligibility requirements for TennCare Standard is that applicants must be current on premium payments, TCMIS will notify DHS whenever a person's eligibility is terminated in TCMIS for failure to pay premiums.

6.1.2.5 Provider Enrollment

The provider enrollment subsystem maintains provider numbers for Medicare crossover providers, out-of-state providers and TennCare Only providers. All providers contracting with a TennCare MCC must obtain a TennCare provider number, regardless of whether the MCC tracks or identifies the provider by an alternate number. The subsystem aggregates information from provider application and enrollment forms, provider network files submitted by MCCs, initial enrollment from the Medicare Intermediary and Carrier data, the Medicare Provider Sanction List from CMS, the CMS Clinical Laboratory Improvement Act database, Tennessee Department of Children's Services, Tennessee Department of Mental Health and Developmental Disabilities, and Tennessee Department of Health provider data. The Provider Enrollment file is used to monitor provider networks, generate provider mailings, track and report provider enrollment statistics, and for claims and encounter claims processing. Going forward, once the National Provider Identifier is implemented, each provider will be associated with a unique provider identifier, following HIPAA rules.

6.1.2.6 Third Party Liability

The Third Party Liability (TPL) subsystem ensures that TennCare is the payer of last resort of services provided to TennCare enrollees. TPL information is maintained in TCMIS to provide the capability to manage cost avoidance and cost recoveries of claims paid.

6.1.3 Decision Support System

TennCare is currently implementing a Decision Support System to support management information needs and program integrity efforts. The system will provide defined reports, dashboards and analysis while also supporting ad hoc reporting needs. The project objective is to make program utilization, financial and operational data more accessible and to support informed decision making.

6.1.4 Production and Ad Hoc Reporting

The TennCare production and ad hoc reporting systems support a variety of activities. TCMIS reporting capabilities are used to produce routine management reports, operational reports, required federal and state reports, to monitor MCC performance, and to support financial and clinical studies.

6.1.3.1 Federal Reporting Requirements

The federal reports listed below are produced from data stored in TCMIS and affiliated systems. A description of these reports can be found in section 6.4.

- Medicaid Program Budget Report – CMS-37
- Quarterly Expense Report – CMS-64
- Annual Report on Home and Community-Based Services Waivers – CMS-372 and CMS-372(s)
- EPSDT Report – CMS-416
- Quarterly Person-Specific Eligibility and Paid Claims Data – CMS-2082 (MSIS)

6.1.5 MCO/BHO Monitoring

TCMIS assists several TennCare Bureau divisions in completing their MCC monitoring activities, including:

- Monitoring MCC program administration
- Monitoring enrollment growth, expenditures and cost trends
- Monitoring provider network adequacy
- Monitoring quality and access to care
- Monitoring contract compliance

Additionally, the Tennessee Department of Commerce and Insurance monitors the financial solvency of the MCCs, analyzes their annual financial statements, and performs onsite audits of their claims processing for accuracy and timeliness of processing.

6.1.6 EPSDT Tracking System

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program provides health screenings and treatment services to TennCare enrollees under the age of 21 to promote early detection of potentially chronic and disabling health conditions. The responsibility for providing EPSDT services to TennCare enrollees has been contracted to the MCOs, with the Quality Oversight Unit performing EPSDT monitoring activities to ensure compliance with federal EPSDT requirements.

TCMIS includes an EPSDT component to support the collection and maintenance of information related to EPSDT and immunization appointments and services. The system includes a mechanism to track whether persons are missing services and to generate reminder notices about up-coming and over-due appointments. This centralized system provides TennCare with the ability to track EPSDT and immunization status as members transfer from one MCO or BHO to another.

6.1.7 HIPAA Compliance

The Health Insurance Portability and Accountability Act (HIPAA), and in particular, HIPAA's Administrative Simplification (ASA), requires state Medicaid programs to protect confidentiality and security of personal health information. The ASA also requires state Medicaid programs to standardize the process for the submission and processing of Medicaid claims.

The TennCare Bureau has assumed responsibility for HIPAA compliance with respect to the TennCare program and its enrollees. Accordingly, the TennCare Bureau has implemented appropriate physical, technical, and administrative safeguards to ensure confidentiality and security of information relating to TennCare enrollees. The TennCare Bureau has also implemented changes to its interChange claims systems that incorporates current HIPAA transaction format standards for required transactions. This system provides configurable logging for audit purposes and supports granular definitions of access to ensure the appropriate use of data. The system also employs a flexible translator module in order to accommodate future transaction standards, including version upgrades of transaction formats and the implementation of the National Provider Identifier.

Despite these achievements, the TennCare Bureau continues to refine its current processes and policies to protect information relating to TennCare enrollees.

6.2 Budget Neutrality

The Bureau of TennCare is responsible for assuring that major expenditures remain within the federal financial participation cap. The TennCare Bureau's Health Informatics and Fiscal Services Division have primary responsibility for monitoring TennCare budget neutrality. The process for performing this function is that which has been laid out by CMS and is as follows:

The following describes the method by which budget neutrality will be assured under the TennCare demonstration beginning July 1, 2002. In general, Tennessee will be using a per capita cost method, and demonstration budget targets will be set on a yearly basis, with a cumulative five-year budget limit.

Individuals who are eligible under the demonstration will be one of three types: (1) those who are currently eligible under Tennessee's existing Medicaid State plan; (2) those who could be eligible for Medicaid if Tennessee amended its State plan; and (3) those who could not be eligible without section 1115 authority. Tennessee will be at risk for the per capita cost (as determined by the method described below) for current eligibles (as defined by groups 1 and 2 above) but not at risk for the number of current eligibles. By providing FFP for all current eligibles, Tennessee will not be at risk for changing economic conditions. However, by placing Tennessee at risk for the per capita costs for current eligibles, CMS assures that the demonstration expenditures do not exceed the level of expenditures had there been no demonstration. Tennessee will be at risk for both enrollment and expenditure growth for demonstration eligibles who could not be eligible without section 1115 authority (as defined by group 3 above).

Each yearly expenditure target for TennCare will be the sum of two budget components: (A) the projected cost of services by specified MEGs; and (B) the projected Disproportionate Share Hospital (DSH) adjustment. Each of these components has a distinct method for projecting costs into the future. Administrative costs under the demonstration will be excluded from the budget neutrality formula except as explained elsewhere.

There are two steps involved in the calculation of the projected cost of services (A above) budget limit: determining baseline estimates of the number of Medicaid eligibles and the cost per eligible; and determining the method for inflating these estimates over time.

The initial per capita cost estimate will be based on the 1992 per capita costs of Medicaid eligibles, inflated to reflect SFY 2002 expenditures. That amount will be trended to cover SFY 2003 using the National Medicaid Health Expenditures trend rate. The per capita costs will be calculated for Children, Disabled, Adults over 65, and Other Adults. The 1992 and SFY 2003 monthly Per Member Per Month (PMPM) amounts for these groups and the specific growth rates for the PMPM amounts for remaining four years of the demonstration are listed below:

	PMPM Expenditures		**Annual Demonstration Trend Rates**			
	SFY 1992	SFY 2003/ DY-1	DY-2	DY-3	DY-4	DY-5
Children	$ 107.07	$ 230.19	7.98%	7.98%	7.98%	7.98%
Disabled	$ 339.57	$ 730.05	7.84%	7.84%	7.84%	7.84%
Over 65	$ 147.75	$ 317.64	6.18%	6.18%	6.18%	6.18%
Adults	$ 211.68	$ 455.09	7.75%	7.75%	7.75%	7.75%

The annual limit on Medicaid expenditures will be the sum of the DSH adjustment for that year and the products of the inflated per capita cost estimate for that year times the number of Medicaid eligibles (limited to those who would have been eligible without the demonstration, including optional populations that could have been authorized under State Plan Amendments) for each of the four eligibility groups.

The DSH adjustment is based on DSH payments made by Tennessee in 1992 and calculated in accordance with current law. The DSH adjustment for the initial year of the demonstration (SFY 2003) is $413,700,907. The DSH adjustment for each subsequent year shall be the previous demonstration year's adjustment trended by the CPI-U for that year, as published three months after the end of the demonstration year. In this manner, Tennessee will have available funding for DSH adjustments similar to other States. The calculation of the DSH adjustment will be appropriately adjusted if Congress enacts legislation which impacts the calculation of DSH allotments.

The CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memorandums or regulation with respect to the provision of services covered under this demonstration. The CMS reserves the right to make adjustments to the budget neutrality cap if any health care related tax that was in effect during the base year with respect to the provision of services covered under this demonstration, or provider related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

Budget neutrality will be determined over a five-year basis. Any annual savings from budget neutrality may only be applied to an eligibility expansion or to offset demonstration costs in excess of the annual budget limits during this period. The state must submit for CMS approval a demonstration amendment requesting the expansion. In its amendment, the state must demonstrate that the expansion is sustainable, even when the accrued savings from this five-year demonstration period are exhausted.

CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, no later than 6 months after the end of an individual demonstration year, Tennessee will calculate annual expenditure targets for the completed year for each of the demonstration components. The annual component targets will be summed to calculate a target annual spending limit. This amount should be compared with the actual amount claimed for FFP. Using the below schedule as a guide, if Tennessee exceeds these targets they shall submit a corrective action plan to CMS for approval.

Year	Cumulative target definition	Percentage
Year 1	Year 1 budget neutrality cap plus	8 percent
Year 2	Years 1 and 2 combined budget neutrality cap plus	3 percent
Year 3	Years 1 through 3 combined budget neutrality cap plus	1 percent
Year 4	Years 1 through 4 combined budget neutrality cap plus	0.5 percent
Year 5	Years 1 through 5 combined budget neutrality cap plus	0 percent

The term "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member/months to the total. Two individuals who are eligible for two months each contribute two eligible member/months to the total, for a total of four eligible member/months.

6.3 Federal Financial Participation

In order to receive federal reimbursement for which states are entitled under Title XIX, TennCare shall submit quarterly reports (CMS-37 and CMS-64) to CMS as described in Section D below. These reports shall be the basis for which TennCare reports all Medicaid and TennCare administrative and service expenditures allowed under the waivers approved for the operation of TennCare.

6.4 Financial Reporting

6.4.1 Medicaid Program Budget Report -- CMS-37

Responsibility: Financial Operations
Frequency: Quarterly

The CMS-37 is a quarterly financial report submitted by TennCare which provides a statement of TennCare's funding requirements for a quarter and estimates matchable Medicaid and TennCare expenditures underlying assumptions for two fiscal years (FYs) -- the current FY and the budget FY. CMS makes federal funds available each quarter based on approved estimates. In order to receive federal financial participation, TennCare must certify that the requisite matching state and local funds are, or will be, available for the certified quarter. This information is supplied to CMS electronically.

6.4.2 Quarterly Expense Report -- CMS-64

Responsibility: Financial Operations
Frequency: Quarterly, within 30 days after the end of each quarter

The CMS-64 is a statement of expenditures for which states are entitled to federal reimbursement under Title XIX and which reconciles the funding advance made on the basis of the CMS-37 (discussed above) for the same quarter. TennCare reports on this form all Medicaid and TennCare administrative and service expenditures allowed under the waivers approved for the operation of TennCare. When completed, the report shows actual Medicaid and matchable TennCare expenditures made in the preceding quarter. CMS reconciles actual expenditures reported in the CMS-64 with federal funding made available for the corresponding period.

6.4.3 Actual CPE

Responsibility: Financial Operations
Frequency: Annually (fiscal year basis), within twelve months of the end of the year

TennCare reports actual hospital certified public expenditures to CMS within twelve months of the end of TennCare's fiscal year. Expenditures are based on hospital cost and revenue data that has been reviewed by the Comptroller of the Treasury.

6.4.4 Person-Specific Eligibility and Paid Claims Data

Responsibility: Information Systems
Frequency: Quarterly

TennCare submits person-specific eligibility and paid claims data to CMS electronically on a quarterly basis. Five files are included in the quarterly submission: eligibility data; inpatient claims; long term institutional care; prescription drug claims; and all other claims.

6.4.5 Annual Report on Home and Community-Based Services Waivers -- CMS-372 and/or CMS-372(s)

Responsibility: Long Term Care Unit
Frequency: Annually, within 180 days of the end of the waiver year

TennCare submits a separate CMS-372/CMS-372(s) for each of its Home and Community Based Services Waiver Programs: the Arlington Home and Community Based Services Waiver for the Mentally Retarded; the Home and Community Based Services Waiver for the Mentally Retarded; and the Home and Community Based Services Waiver for the Elderly and Disabled. These reports are used by CMS to compare the actual number of services and expenditures incurred under the waiver with the original estimates.

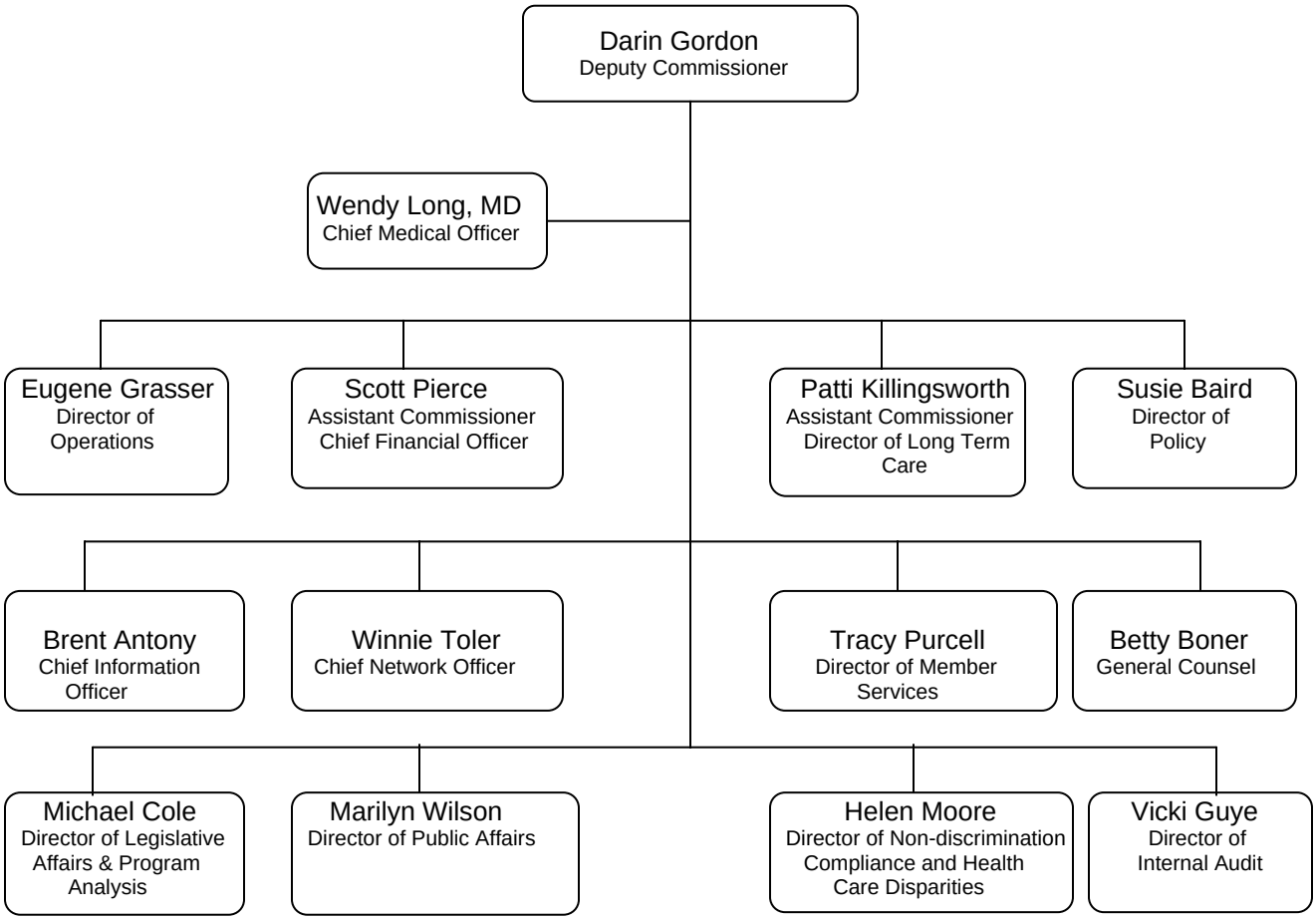
Attachments

Attachment

A	**Bureau of TennCare Organization Chart**
B	**Qualifying Diagnoses for Medical Eligibility**
C	**List of Current Managed Care Contractors (MCCs)**
D	**Hardship Criteria for MCO Changes**
E	**Helpful Telephone Numbers**
F	**TennCare Physical and Behavioral Health Benefits**
G	**Special Terms and Conditions for Access**
H	**Amendments**

Attachment A

Bureau of TennCare
Organization Chart



Attachment B

Qualifying Medical Conditions Used to Determine Medical Eligibility

- ❑ Alpha-1-Antitrypsin Deficiency 277.6
- ❑ ALS 335.20
- ❑ Alzheimer's 331.0
- ❑ Arrhythmias 426-426.9, 427-427.9
- ❑ Arthrogryposis 728.3
- ❑ Asbestosis 501
- ❑ Ataxia Telangiectasia 334.8
- ❑ Autism 299.0, 299.1, 299.8, 299.9
- ❑ Bipolar Disorders 296.1, 296.3, 296.4, 296.5, 296.6, 296.7, 296.8-296.89
- ❑ Cancer, with active treatment in past 12 months (includes Hodgkin's Disease, leukemia, lymphoblastoma, lymphoma, malignant tumor, melanoma, and sarcoma) 140-149,150-159,160-165, 170-172, 174-176, 179-189, 190-197, 198-199, 200-208
- ❑ Cardiac Pacemakers V45.0, V45.00-V45.09
- ❑ Cardiomyopathy 425, 425.0-425.9
- ❑ Cerebral Palsy 343, 343.0-343.9
- ❑ Cerebrovascular Accidents (Thrombosis/ Hemorrhage) 430, 431, 432, 432.0-432.9, 433.0-433.9, 434, 434.1-434.9, 436
- ❑ Chronic Obstructive Pulmonary Disease (COPD) 496, 491.2-491.9, 492.0, 492.8
- ❑ Chronic Pancreatitis 577.1
- ❑ Cirrhosis of the Liver 571.5, 571.6
- ❑ Coagulation Defects (Hemophilias, Christmas Disease, and other clotting factor disorders) 286.0-286.9
- ❑ Congenital Adrenal Hyperplasia 255.2
- ❑ Congenital Heart Disease 745.0-745.9, 746.0-746.9, 747.0-747.49
- ❑ Congenital Hypothyroidism 243
- ❑ Congestive Heart Failure 428.0-428.9

Coronary Artery Disease (Myocardial Infarctions, Open Heart Surgery) 410.0-410.9, 411.0-411.89, 412, 413.0-413.9, 414.0-414.9

- ❑ Crohn's Disease 555.0-555.9
- ❑ Cystic Fibrosis 277.0, 277.01
- ❑ Demyelinating Diseases 340, 341.0-341.9
- ❑ Diabetes, Type 1, with comorbidity; Juvenile Diabetes 250.1-250.9
- ❑ Down Syndrome 758.0
- ❑ Epilepsy 345.0-345.9
- ❑ Esophageal Varicies 456.0, 456.1, 456.2
- ❑ Fetal Alcohol Syndrome 760.71
- ❑ Fragile X-Syndrome 759.83
- ❑ Friedreich's Ataxia 334.0
- ❑ Galactosemia 271.1
- ❑ Hamman-Rich Disease 516.3
- ❑ Heart Valve Replacement V42.2
- ❑ Hepatitis C 070.41, 070.44, 070.51, 070.54
- ❑ HIV/AIDS 042, 079.53, 136.3, 176.0-176.9
- ❑ Huntington's Chorea 333.4
- ❑ Hydrocephalus 742.3
- ❑ Kidney Failure, with dialysis 584.5-584.9, 585, 586
- ❑ Lead Poisoning 961.2, 984.0-984.9
- ❑ Leukodystrophies 330.0
- ❑ Lipidosis 272.7
- ❑ Maple Syrup Urine Disease 270.3
- ❑ Marfan's Syndrome 759.82
- ❑ Mucopolysaccharidosis 277.5 (types 1-6)
- ❑ Multiple Sclerosis 340
- ❑ Muscular Dystrophies 359.0, 359.1,359.2, 359.3
- ❑ Myasthenia Gravis 358.0
- ❑ Neurofibromatosis 237.70, 237.71,237.72
- ❑ Prader-Willi Syndrome 759.81
- ❑ Prune Belly Syndrome 756.71
- ❑ Spina Bifida 741.0-741.9
- ❑ Osteogenesis Imperfecta 756.51
- ❑ Parkinson's Disease 332.0, 333.0
- ❑ Phenylketonuria (PKU) 270.1
- ❑ Polyarteritis Nodosa 446.0
- ❑ Polycystic Renal Disease 753.12-753.14
- ❑ Psychotic Disorders (including Schizophrenia) 295.0-295.9, 296.0-296.9, 297.0-297.9, 298.0-298.9, 299.0-299.9
- ❑ Quadriplegia 344.00-344.09
- ❑ Rheumatic Heart Disease 391.0-391.9, 392.0-392.9, 393, 394.0, 394.1, 395.0-395.9, 396.0-396.9, 397.0-397.9, 398.0-398.99
- ❑ Rheumatoid Arthritis 714.0-714.89
- ❑ Scleroderma 710.1
- ❑ Sickle Cell Disease 282.60-286.69
- ❑ Still's Disease 714.30
- ❑ Syringomyelia 336.0
- ❑ Systemic Lupus Erythematosis 710.0
- ❑ Thalassemia Major 282.4
- ❑ Traumatic Brain Injury 850.4, 851.0-851.9
- ❑ Tuberculosis 011.0-011.9, 012.0-012.8, 013.0-013.9, 014.0-014.8, 015.0-015.9, 016.0-016.9, 017.0-017.9, 018.0-018.9
- ❑ Ulcerative Colitis 556.0-556.9
- ❑ Wilson's Disease 275.1

<u>Organ Transplant</u>

- ❑ Bone Marrow V42.81
- ❑ Cornea V42.5
- ❑ Heart V42.1
- ❑ Heart Valve V42.2, V43.3
- ❑ Intestines V42.84
- ❑ Kidney V42.0
- ❑ Liver V42.7
- ❑ Lung V42.6
- ❑ Pancreas V42.83

<u>Surgery</u>

- ❑ Open Heart Surgery (CPT Codes) 33517-33530, 33533-33545, 33572, 33510-33516

Attachment C

List of Current Managed Care Contractors (MCCs)

Managed Care Organizations (MCOs)

AmeriChoice (East)
Executive Tower I
408 North Cedar Bluff Road Suite 400
Knoxville, TN 37923
1-800-209-0034

AmeriChoice (Middle)
10 Cadillac Drive Suite 200
Brentwood, Tennessee 37027
1-800-690-1606
[New MCO Effective April 1, 2007]

AmeriGroup
3 Lakeview Place
22 Century Blvd., Suite 310
Nashville, TN 37214
1-800-600-4441
[New MCO Effective April 1, 2007]

BlueCare
801 Pine Street
Chattanooga, TN 37402-2555
1-800-468-9698

Preferred Health Partnership (PHP)
1420 Centerpoint Blvd.
Knoxville, TN 37932
1-800-747-0008

TLC Family Care Healthplan
P.O. Box 49
Memphis, TN 38101
1-800-473-6523 (901-725-7100 in Shelby County)

UAHC Health Plan
1991 Corporate Avenue 5th Floor
Memphis, TN 38132
1-800-876-9758

Unison Administrative Services
300 Oxford Drive
Monroeville, PA 15146-2356
1-800-414-9025

Volunteer State Health Plan
(for both BlueCare and TennCare Select)
801 Pine Street
Chattanooga, TN 37402-2555
TennCare Select 1-800-263-5479
BlueCare 1-800-468-9898

Behavioral Health Organizations (BHOs)

Premier Behavioral Systems of Tennessee and
Tennessee Behavioral Health, Inc.
222 Second Avenue North, Suite 220
Nashville, TN 37201
Premier 1-800-325-7864
TBH 1-800-447-7242

Dental Benefits Manager (DBM)

Doral Dental of Tennessee, LLC
3200 West End Avenue, Suite 500
Nashville, TN 37203
1-888-233-5935

Pharmacy Benefits Manager (PBM)

First Health Services Corporation
4300 Cox Road
Glen Allen, VA 23060
1-800-884-2822

Attachment D

Medical Hardship Criteria for MCO Changes

The following criteria must be met to direct a hardship MCO change. If these criteria are not met, and the enrollee has ongoing concerns about their PCP or specialty care, TennCare will work with his current plan, resolve the concerns, and ensure appropriate care is provided. Deficiencies in MCO networks will be communicated to contract compliance and quality oversight units for review and assessment of appropriate sanctions or damages. An enrollee for whom a hardship MCO change is denied will be given an opportunity to file an appeal if he desires to do so.

Hardship Criteria:

1. An enrollee has a medical condition that requires complex, extensive and ongoing care.
2. Enrollee's PCP and/or specialist dropped from the enrollee's current MCO network and are refusing continuation of care to the enrollee under their current MCO.
3. The ongoing medical condition of the enrollee is such that another physician or provider with appropriate expertise would be unable to take over their care without significant and negative impact on their condition
4. Current MCO has been unable to negotiate continued care for this enrollee with current PCP and/or specialist.
5. Current provider is in network for one or more alternate MCO.
6. Alternate MCO is available to enrolled new members (i.e. has not given notice of withdrawal from TennCare, is not in receivership, and is not at member capacity for region in question).

Hardship MCO change will NOT be granted in the following situations:

1. Enrollee is unhappy with current plan or PCP, but no hardship medical situation exists.
2. Current MCO has deficiencies in its network of providers.
3. Enrollee is unhappy with a current PCP or other providers, and has refused alternative PCP or provider choices offered by MCO.
4. Enrollee is concerned that a current provider might drop out of the plan in the future.
5. Medicare recipients who (with the exception of pharmacy) may utilize their choice of providers, regardless of network affiliation.

Routine MCO hardship changes will be directed or referred to the Administrative Solutions Call Center to process.

Examples of routine MCO hardship changes allowed under TennCare rules include:

1. MCO change requested within 45 calendar days (inclusive of mail time) of the date of the letter that provides notification of health plan assignment
2. MCO changes requested because all immediate family members were not assigned to the same plan.
3. When an enrollee changes place of residence, thus moving out of a plan's service area.
4. When an administrative error has occurred in assigning an enrollee to a plan not serving their geographic area.

Attachment E

Helpful Telephone Numbers

Family Assistance Service Center
1-866-311-4287 (743-2000 in the Nashville area)

TennCare TTY Information Line for persons with speech & hearing impairments
1-800-772-7647 (313-9240)

TennCare Spanish-speaking Information Line
1-800-254-7568 (337-7568 in the Nashville area)

TennCare Consumer Advocacy Line
(A subsidiary of Health Assist Tennessee)
1-800-722-7474 (313-9841 in the Nashville area)

TennCare Partners Advocacy Line
1-800-758-1638 (242-7339 in the Nashville area)

Statewide Mental Health Crisis Line
1-800-809-9957

TennCare Solutions Unit (TSU)
1-800-878-3192 (253-4473 in the Nashville area)

Bureau of TennCare Office
1-800-342-3145 (507-6000 in the Nashville area)

TennCare Fraud and Abuse Line
1-800-433-3982
FAX (615) 532-7509
E-mail address: TennCarefraud@state.tn.us

Legislative Response Unit (TennCare)
1-615-507-6455

Bureau of TennCare website: www.tennessee.gov/tenncare

Attachment F

TennCare Physical & Behavioral Health Benefits

[Note: **Both** = coverage of service/item the same for both children and adults.]

SERVICE	BENEFIT
Ambulance Services	See Emergency Air and Ground Transportation, Non-Emergency Ambulance Transportation, and Non-Emergency Transportation.
Bariatric Surgery, defined as surgery to induce weight loss.	**Both:** Covered as medically necessary and in accordance with clinical guidelines established by the Bureau of TennCare.
Chiropractic services [defined at 42 CFR § 440.60(b)]	**Under age 21:** Covered as medically necessary. **Age 21 and older**: Not covered, except may be provided as a cost effective alternative at the sole discretion of the MCO.
Community Health Services [defined at 42 CFR § 440.20(b) and (c) and 42 CFR § 440.90]	**Both:** Covered as medically necessary.
Dental Services [defined at 42 CFR § 440.100]	**Under age 21:** Preventive, diagnostic and treatment services for enrollees covered as medically necessary. Dental services under EPSDT, including dental screens, are provided in accordance with the state's periodicity scheduled after consultation with recognized dental organizations and at other intervals as medically necessary. Orthodontic services must be prior approved and are limited to individuals under age 21 requiring these services: (1) because of a severe handicapping malocclusion or another developmental anomaly or injury resulting in severe misalignment or severe handicapping malocclusion of teeth, documented by at least 28 points on the Salzmann Scale, or any other method that is approved by TennCare; or (2) following repair of an enrollee's cleft palate. Orthodontic treatment will not be authorized for cosmetic purposes. Orthodontic treatment will be paid for by TennCare only as long as the individual remains eligible for TennCare. If the orthodontic treatment plan is approved prior to the enrollee's attaining 20 ½ years of age, and treatment is initiated prior to the enrollee's attaining 21 years of age, such treatment may continue as long as the enrollee remains eligible for TennCare. The MCO is responsible for the provision of transportation to and from covered dental services, as well as the medical and anesthesia services related to the covered dental services. **Age 21 and older:** Not covered, except for orthodontic services when a treatment plan was prior approved prior to the enrollee's obtaining 20 ½ years of age, and treatment initiated prior to the enrollee's attaining 21 years of age; such treatment may continue as long as the enrollee remains eligible for TennCare.
Durable Medical Equipment [defined at 42 CFR § 440.70(b)(3) and 42 CFR § 440.120(c)]	**Both:** Covered as medically necessary.

Emergency Air and Ground Ambulance Transportation [defined at 42 CFR § 440.170(a)(1) and (3)]	**Both:** Covered as medically necessary.
Preventive, Diagnostic and Treatment Services for Persons Under age 21 [EPSDT] **[defined at 42 CFR 441 Subpart B]**	**Under age 21:** Screening and interperiodic screening covered in accordance with federal regulations. (Interperiodic screens are screens in between regular checkups which are covered if a parent or caregiver suspects there may be a problem.) Diagnostic and follow-up treatment services covered as medically necessary and in accordance with federal regulations. The periodicity schedule for child health screens is that set forth in the latest "American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care." All components of the screens must be consistent with the latest "American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care." **Age 21 and older:** Not applicable.
Home Health Care [defined at 42 CFR § 440.70(a), (b), (c), and (e)]	**Both:** Covered as medically necessary. All home health care must be delivered by a licensed Home Health Agency, as defined by 42 CFR §440.70. A home health visit includes any of the following: Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services, and Home Health Aide.
Hospice Care [defined at 42 CFR Part 418]	**Both:** Covered as medically necessary. Must be provided by an organization certified pursuant to Medicare Hospice requirements.
Inpatient and Outpatient Substance Abuse Benefits [defined as services for the treatment of substance abuse that are provided (a) in an inpatient hospital (as defined at 42 CFR § 440.10) or (b) as outpatient hospital services (see 42 CFR § 440.20(a)]	**Under age 21:** Covered as medically necessary. **Age 21 and older:** Covered as medically necessary, with a maximum lifetime limitation of 10 detoxification days and $30,000 in substance abuse benefits (inpatient, residential, and outpatient). When medically appropriate and cost effective as determined by the BHO, services in a licensed substance abuse residential treatment facility may be substituted for inpatient substance abuse services.
Inpatient Hospital Services [defined at 42 CFR § 440.10]	**Both:** Covered as medically necessary. MCO may conduct preadmission and concurrent reviews. **Age 21 and older:** Inpatient Rehabilitation Facilities services may be provided as a cost effective alternative ~~by~~ at the sole discretion of the MCO.
Inpatient Rehabilitation Facility Services	See Inpatient Hospital Services.
Lab and X-Ray Services [defined at 42 CFR § 440.30]	**Both:** Covered as medically necessary.
Medical Supplies [defined at 42 CFR § 440.70(b)(3)]	**Both:** Covered as medically necessary.
Mental Health Case Management Services [defined as services rendered to support outpatient mental health clinical services]	**Both:** Covered as medically necessary.

Mental Health Crisis Services [defined as services rendered to alleviate a psychiatric emergency]	**Both:** Covered as medically necessary.
Methadone Clinic Services [defined as services provided by a methadone clinic]	**Under age 21:** Covered as medically necessary. **Age 21 and older:** Not covered.
Non-Emergency Ambulance Transportation [defined at 42 CFR § 440.170(a)(1) and (3)]	**Both:** Covered as medically necessary.
Non-Emergency Transportation **[defined at 42 CFR § 440.170(a)(1) and (3)]**	**Both:** Covered as medically necessary for enrollees lacking accessible transportation for covered services. The travel to access primary care and dental services must meet the requirements of the TennCare demonstration project terms and conditions. The availability of specialty services as related to travel distance should meet the usual and customary standards for the community. However, in the event the MCO is unable to negotiate such an arrangement for an enrollee, transportation must be provided regardless of whether or not the enrollee has access to transportation. **Under age 21:** If the enrollee is a minor child, transportation must be provided for the child and an accompanying adult. However, transportation for a minor child shall not be denied pursuant to any policy which poses a blanket restriction due to enrollee's age or lack of parental accompaniment. Any decision to deny transportation of a child due to an enrollee's age or lack of parental accompaniment must be made on a case-by-case basis and must be based on the individual facts surrounding the request. As with any denial, all notices and actions must be in accordance with the appeal process. Tennessee recognizes the "mature minor exception" to permission for medical treatment. The provision of transportation to and from covered dental services is the responsibility of the MCO.
Occupational Therapy [defined at 42 CFR § 440.110(b)]	**Under age 21:** Covered as medically necessary, by a Licensed Occupational Therapist, to restore, improve, or stabilize or ameliorate impaired functions. **Age 21 and older:** Covered as medically necessary, by a Licensed Occupational Therapist, to restore, improve, or stabilize impaired functions.
Organ and Tissue Transplant Services and Donor Organ/Tissue Procurement Services [defined as the transfer of an organ or tissue from one individual to another]	**Under age 21:** Covered as medically necessary. **Age 21 and older:** Covered as medically necessary when coverable by Medicare. **Both:** Experimental or investigational transplants are not covered for any enrollee.

Outpatient Hospital Services [defined at 42 CFR § 440.20(a)]	**Both:** Covered as medically necessary.
Outpatient Mental Health Services (including physician services) [defined at 42 CFR § 440.20(a), 42 CFR § 440.50, and 42 CFR § 440.90]	**Both:** Covered as medically necessary.
Pharmacy Services [defined at 42 CFR § 440.120(a) and obtained directly from an ambulatory retail pharmacy setting, outpatient hospital pharmacy, mail order pharmacy or those administered to a long-term care facility (nursing facility) resident]	**Under age 21:** Covered as medically necessary. Certain drugs (known as DESI, LTE, IRS drugs) are excluded from coverage. Pharmacy services are the responsibility of the PBM, except for pharmaceuticals supplied and administered in a doctor's office. For persons who are not dually eligible for Medicare and Medicaid, pharmaceuticals supplied and administered in a doctor's office are the responsibility of the MCO. For persons who are dually eligible for Medicare and Medicaid, pharmaceuticals supplied and administered in a doctor's office are the responsibility of the MCO if not covered by Medicare. **Age 21 and older with TennCare Medicaid and with TennCare Standard (SSD):** Covered as medically necessary subject to the limitations below. Certain drugs (known as DESI, LTE, IRS drugs) are excluded form coverage. Pharmacy services are the responsibility of the PBM, except for pharmaceuticals supplied and administered in a doctor's office. For persons who are not dually eligible for Medicare and Medicaid, pharmaceuticals supplied and administered in a doctor's office are the responsibility of the MCO. For persons who are dually eligible for Medicare and Medicaid, pharmaceuticals supplied and administered in a doctor's office are not covered by TennCare. (A) Pharmacy services for individuals receiving TennCare-reimbursed services in a Nursing Facility, Intermediate Care Facility for the Mentally Retarded, or a Home and Community Based Services waiver have no quantity limits on the number of prescriptions per month. (B) Subject to (A) above, pharmacy services for Medicaid adults age 21 and older are limited to five (5) prescriptions and/or refills per enrollee per month, of which no more than two (2) of the five (5) can be brand name drugs. Additional drugs for individuals in (B) shall not be covered. Prescriptions shall be counted beginning on the first of each calendar month. Each prescription and/or refill counts as one (1). A prescription or refill can be for no more than a thirty-one (31) day supply. The Bureau of TennCare shall maintain a Pharmacy Auto Exemption List of pharmacy services which shall not count against such limit. The Pharmacy Auto Exemption List may be modified at the discretion of the Bureau of TennCare. The most current version of the Pharmacy Auto Exemption List will be made available to enrollees via the internet from the TennCare website and upon request by mail through the DHS Family Service Assistance Centers. Only drugs that are specified on the version of the Pharmacy Auto Exemption List that is available on the TennCare website located on the World Wide Web at www.state.tn.us/tenncare and indicated as current as of the date of service shall be considered exempt from applicable pharmacy limits. Unless specified on the version of the Pharmacy Auto Exemption List which is current as of the date of the pharmacy service, pharmacy services in excess of five (5) prescriptions and/or refills per enrollee per month or

	two (2) brand name drugs per enrollee per month are non-covered services. (C) Over-the-counter drugs for Medicaid adults are not covered even if the enrollee has a prescription for such service, except for prenatal vitamins for pregnant women. The Bureau of TennCare shall also maintain a Pharmacy Prescriber Attestation List of medications that can be accessed for enrollees who have reached a benefit limit and whose providers attest that the medication is urgently needed. Medications from the Pharmacy Prescriber Attestation List will be covered if, and only if, the prescriber seeks and obtains a special exemption from the otherwise applicable benefit limit. **Age 21 and older with TennCare Standard (not SSD):** Not covered.
Physical Therapy [defined at 42 CFR § 440.110(a)]	**Under age 21:** Covered as medically necessary, by a Licensed Physical Therapist, to restore, improve, ameliorate, or stabilized impaired functions. **Age 21 and older:** Covered as medically necessary, by a Licensed Physical Therapist, to restore, improve, or stabilized impaired functions.
Physician Inpatient Services [defined at 42 CFR § 440.50]	**Both:** Covered as medically necessary.
Physician Outpatient Services/Community Health Clinics/Other Clinic Services [defined at 42 CFR § 440.20(b), 42 CFR § 440.50, and 42 CFR § 440.90]	**Under age 21:** Covered as medically necessary. **Age 21 and older:** Covered as medically necessary, except see Methadone Clinic Services. Services provided by a Primary Care Provider when the enrollee has a primary behavioral health diagnosis (ICD-9CM 290.xx – 319.xx) are the responsibility of the MCO. Medical evaluations provided by a neurologist, as approved by the MCO, and/or an emergency room provider to establish a primary behavioral health diagnosis are the responsibility of the MCO.
Private Duty Nursing [defined at 42 CFR § 440.80]	**Both:** Covered as medically necessary when prescribed by an attending physician for treatment and services rendered by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), who is not an immediate relative. Must be prior authorized in accordance with state rules.
Psychiatric Inpatient Facility Services [defined at 42 CFR § 441, Subparts C and D and including services for persons of all ages]	**Both:** Covered as medically necessary. Preadmission and concurrent reviews by the MCC are allowed.
Psychiatric Pharmacy Services	See Pharmacy Services
Psychiatric Physician Inpatient Services [defined at 42 CFR § 440.50]	**Both:** Covered as medically necessary.
Psychiatric Physician Outpatient Services	See Outpatient Mental Health Services
Psychiatric Rehabilitation Services [defined as psychiatric services delivered in accordance with 42 CFR § 440.130(d)]	**Both:** Covered as medically necessary.

Psychiatric Residential Treatment Services [defined at 42 CFR § 483.352] and including services for persons of all ages	**Both:** Covered as medically necessary.
Reconstructive Breast Surgery [defined in accordance with Tenn. Code Ann. § 56-7-2507]	**Both:** Covered in accordance with Tenn. Code Ann. § 56-7-2507 which requires coverage of all stages of reconstructive breast surgery on a diseased breast as a result of a mastectomy as well as any surgical procedure on the non-diseased breast deemed necessary to establish symmetry between the two breasts in the manner chosen by the physician. The surgical procedure performed on a non-diseased breast to establish symmetry with the diseased breast will only be covered if the surgical procedure performed on a non-diseased breast occurs within five (5) years of the date the reconstructive breast surgery was performed on a diseased breast.
Rehabilitation Services	See Inpatient Rehabilitation Facility, Occupational Therapy, Physical Therapy, and Speech Therapy.
Renal Dialysis Clinic Services [defined at 42 CFR § 440.90]	**Both:** Covered as medically necessary. Generally limited to the beginning 90-day period prior to the enrollee's becoming eligible for coverage by the Medicare program.
Speech Therapy [defined at 42 CFR § 440.110(c)]	**Under age 21:** Covered as medically necessary, by a Licensed Speech Therapist to restore, improve, stabilize, or ameliorate impaired functions. **Age 21 and older:** Covered as medically necessary as long as there is continued medical progress, by a Licensed Speech Therapist to restore speech after a loss or impairment.
Transportation	See Emergency Air and Ground Transportation, Non-Emergency Ambulance Transportation, and Non-Emergency Transportation.
Vision Services [defined as services to treat conditions of the eyes]	**Under age 21:** Preventive, diagnostic, and treatment services (including eyeglasses) are covered as medically necessary. **Age 21 and older:** Medical eye care, meaning evaluation and management of abnormal conditions, diseases, and disorders of the eye (not including evaluation and treatment of the refractive state) is covered. Routine, periodic assessment, evaluation or screening of normal eyes, and examinations for the purpose of prescribing, fitting, or changing eyeglasses and/or contact lenses are not covered. The first pair of cataract glasses or contact lens/lenses following cataract surgery is covered for adults.

Attachment G

Special Terms and Conditions for Access

Source: Approval letter for the new TennCare waiver from the Centers for Medicare and Medicaid Services, May 30, 2002

In general, contractors shall provide available, accessible, and adequate numbers of institutional facilities, service locations, service sites, professional, allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24-hour-a-day, 7-day-a-week basis. At a minimum this shall include:

Primary Care Physician or Extender:

(a) Distance/Time Rural: 30 miles or 30 minutes

(b) Distance/Time Urban: 20 miles or 30 minutes

(c) Patient Load: 2,500 or less for physician; one-half this for a physician extender.

(d) Appointment/Waiting Times: Usual and customary practice (see definition below), not to exceed 3 weeks from the date of a patient's request for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

(e) Documentation/Tracking requirements:

Documentation -- Plans must have a system in place to document appointment scheduling times. The State must utilize statistically valid sampling methods for monitoring compliance with appointment/waiting time standards as part of the survey required in special term and condition 4.

Tracking -- Plans must have a system in place to document the exchange of client information if a provider, other than the primary care provider (i.e., school-based clinic or health department clinic), provides health care.

Specialty Care and Emergency Care:

Referral appointment to specialists (e.g., specialty physician services, hospice care, home health care, substance abuse treatment, rehabilitation services, etc.) shall not exceed 30 days for routine care or 48 hours for urgent care. All emergency care is immediate, at the nearest facility available, regardless of contracts. Waiting times shall not exceed 45 minutes.

Hospitals:

Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where access time may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions must be justified and documented to the State on the basis of community standards.

General Dental Services:

Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where community standards and documentation will apply.

Appointment/Waiting Times: Usual and customary note to exceed 3 weeks for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

General Optometry Services:

Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where community standards and documentation will apply.

Appointment/Waiting Times: Usual and customary note to exceed 3 weeks for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

Pharmacy Services:

Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where community standards and documentation will apply.

Lab and X-Ray Services:

Transport time will be the usual and customary, not to exceed 30 minutes, except in rural areas where community standards and documentation will apply.

Appointment/Waiting Times: Usual and customary note to exceed 3 weeks for regular appointments and 48 hours for urgent care. Waiting times shall not exceed 45 minutes.

Other:

All other services not specified here shall meet the usual and customary standards for the community.

Definition of "Usual and Customary": access that is equal to or greater than the currently existing practice in the fee-for-service system.

Guidelines for State Monitoring of Plans

- The State will require, by contract, that Plans meet certain State-specified standards for Internal Quality Assurance Programs (QAPs) as required in 42 CFR 434.

- The State will monitor, on a periodic or continuous basis (but no less often than every 12 months), Plans' adherence to these standards, through the following mechanism: review of each plan's written QAP, review of numerical data and/or narrative reports describing clinical and related information on health services and outcomes, and on-site monitoring of the implementation of the QAP standards.

- Recipient access to care will be monitored through the following State activities: periodic comparison of the number and types of providers before and after the demonstration, periodic surveys which contain questions concerning recipient access to services, measurement of waiting periods to obtain health care services, and measurement of referral rates to specialists.

Guidelines for Plan Monitoring of Providers

- Plans will require, by contract, that providers meet specified standards as required by the State contract.

- Plans will monitor, on a periodic or continuous basis, providers' adherence to these standards, and recipient access to care.

Attachment H

Amendments